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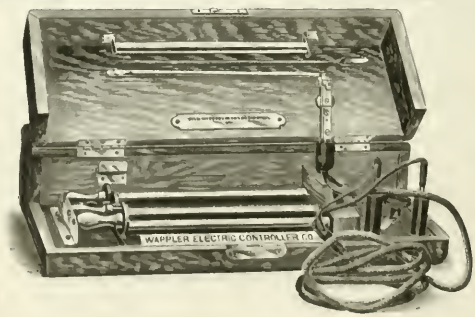

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Announcements.

A CHANGE OF HANDS.

WITH this number, which closes the twentieth volume of the Journal, it passes again into new hands. A syndicate composed of members of the American Dermatological Association, whose announcement appears below, have taken it over, and intend to make it what it should always have been, a medium for presenting the subjects of dermatology and syphilology alone. It is a commonplace that there is no connection between them and genito-urinary disease, especially in its surgical aspect and both specialties have so grown in the last ten years that each needs an organ of its own. Dermatologists are fortunate in being provided for, with the prestige of the old Journal to go upon, for there can be no doubt that there are some contributions too technical to find a place comfortable in the weeklies. Men in the genito-urinary line will doubtless found a periodical of their own, for which the time is ripe. It is ripe, too, to say that they must support it better than they have this. In answer to urgent requests, we received three out of twenty-seven papers read at the last meeting of their national association. In the face of evidence like this, they have threatened to withdraw their support altogether because matter enough in their line has not been published. We hope the syphilis in the new volume will attract them more powerfully. All of us should help it to its feet.

As regards our management, we have little to say. The verdict must be left to the Journal's readers. If we have helped them in any way, we are satisfied; if not (some of the letters received have been pointed enough to lead us to the supposition) our six years of work, annoyance, anxiety even at times, have been useless. We have some knowledge of the esteem in which it is held from the fact that certain

numbers which are out of print cannot be obtained for love or money from those who have them. That we have presented the very best work of American dermatologists and a share of the genito-urinary in that time, there is no reason to doubt. Space limitations have prevented adequate reviews of foreign literature, but little of real importance has failed to appear. The truth is that a good deal of trash appears in our special journals as elsewhere. We have increased the size of the volumes, illustrated them more profusely in half-tone because a good black and white print presents disease more clearly a good deal than the poor lithographs which generally reward illustrating effort in this country. We have succeeded in putting the Journal in the last three years on a paying basis, a condition which had never existed previously.

Lastly, we offer our best thanks to the men who have helped us in every possible way that loyalty could suggest. There are some hundreds of them and it has been quite worth while if the Journal from 1897 to 1903 has won their approval.

JAS. C. JOHNSTON,
GEO. K. SWINBURNE.

ANNOUNCEMENT FOR 1903.

BEGINNING with the new year this Journal will be continued under the editorial management of Dr. James C. White and Dr. John T. Bowen of Boston, Dr. James Nevins Hyde of Chicago, Dr. Henry W. Stelwagon of Philadelphia, Dr. Prince A. Morrow, Dr. Edward B. Bronson, Dr. George T. Jackson and Dr. John A. Fordyce of New York.

Dr. A. D. Mewborn of New York will be the acting editor. The editors will take an active interest in the Journal and by their united efforts hope materially to improve the quality of its contents.

It is their desire to present a monthly review of all important advances in dermatology and syphilis both in this country and abroad.

This Journal has furthermore been made the official organ of the American Dermatological Association and will publish in addition to its transactions the proceedings of all the local societies throughout the country devoted to this specialty.

In the future all communications relating to the editorial department should be addressed to Dr. A. D. Mewborn, 224 West 52d street, New York.

The Journal will be published by The Grafton Press, 70 Fifth avenue, New York, where all inquiries relating to subscriptions, advertisements, etc., should be directed.

Original Communications.

EPIDERMOLYSIS BULLOSA HEREDITARIA.

Report of a Case Presenting Unusual Features.

By Grover William Wende, M.D.,
Clinical Professor of Dermatology, University of Buffalo.

SUMMARY OF CHIEF POINTS. The evidence of the hereditary or congenital formation of vesicles and blebs at points subject to traumatism and irritation; the marked infiltration of the skin after the lesions subside; the arrangement of the bullæ in concentric patches; the decided changes in the nails; the lack of hirsute growth upon the scalp and the absence of eyebrows and eyelashes; the general tenuity of the skin.

J. T., seven years old; born in Canada; first examined, September 23, 1901. Family History: The patient's father and mother are cousins, both being healthy. The grandparents are still alive and quite robust. There is no history of syphilis, neurosis or skin disease of any kind affecting any remote member of the family. There were four children in all; of these a brother, younger than the patient, died at the age of two months from acute bowel trouble. The third child appeared healthy at birth and remained so for almost a year, when a skin eruption showed itself about the mouth and anus, which finally spread to other parts of the body. The eruption gradually became more aggravated, with intervals of comparative relief. Under its influence the child continued to grow weaker; when at the age of two it died without other apparent cause. The fourth child was seemingly hale and vigorous.

Personal History: The patient at birth seemed perfectly well and so continued for three weeks, when he had an attack of diarrhœa, simultaneously with which the skin began to redden about the anus and mouth, both becoming at first moist and afterwards scaly. The precise nature of this affection was difficult to determine. It continued, with variations in extent and form, until the patient had reached the age of three years, when he had an attack of cholera morbus, during the continuance of which there was a brief and complete remission of the skin manifestation. When it reappeared, the development of blisters was first noticed about the fingers, within the palms and

FIG. 1.

upon the back of the hands. Similar lesions were developed upon the soles of the feet, specially involving the heels. There was a recurrence of the blebs about the hands and elsewhere. This state of affairs persisted until the commencement of the hot months, when

there was almost complete remission in the affected parts; but, upon the return of cold weather, the disease again made its appearance not only upon the sites previously attacked, but also upon the knees. During the fourth, fifth and sixth summers the patient was comparatively,

Fig. 2.

although never wholly, free from the complaint. The seizure during the past winter did not result, as usual, in cessation but continued throughout the summer. Vesicles frequently were manifest on the tongue and the mucous membrane of the mouth.

The patient was born with his head well covered with dark hair, which began to fall out immediately upon the advent of the eruption,

occurring when he was about three weeks old. At one year of age he was quite bald, while, at present, only a few straggling hairs disseminated over the surface of the scalp, are discerned.

PRESENT STATE: The patient is a fairly well-developed boy for his age, and, barring the skin disease which prevents him from taking proper exercise, his general health is good. Upon examination no apparent change was found in the sensibility of the skin. The scalp shows, at present, but a few scattered lanugo hairs. The whole cu-

FIG. 3.

taneous structure is extremely thin. No evidence of bleb formation or inflammation of the scalp was ever discovered. It however shows a small pigmentary nævus covered with dark hairs. The eyebrows are merely indicated by scanty lanugo hairs, while the lashes are not entirely wanting. A raw, shiny, elliptic area surrounds the mouth, which is denuded of skin and covered with fine scales, with the exception of this border, which is highly inflammatory; a condition perhaps aggravated by the fact that the patient continually wipes his mouth. An elevated red border encircles the nares, involving the

bridge of the nose and extending over the right cheek, forming a half square, the advancing margin of which is of bright red, testifying to its more recent origin, while the rest of the area is scaly, demonstrating a more chronic state. The cavity of the mouth contains many erosions; on the mucous surfaces of the cheeks are two vesicles. The tongue shows no active lesions, but is smooth, bright red and raw looking at the center, having milk-white spots upon the edges. The breath is foul. The patient complains of pain accompanying mastication and deglutition, especially when eating highly-seasoned food. Extending from the edges of the eyelids is an inflamed area covered with scales which causes an irritation of the conjunctiva. A ciliary blepharitis is likewise present.

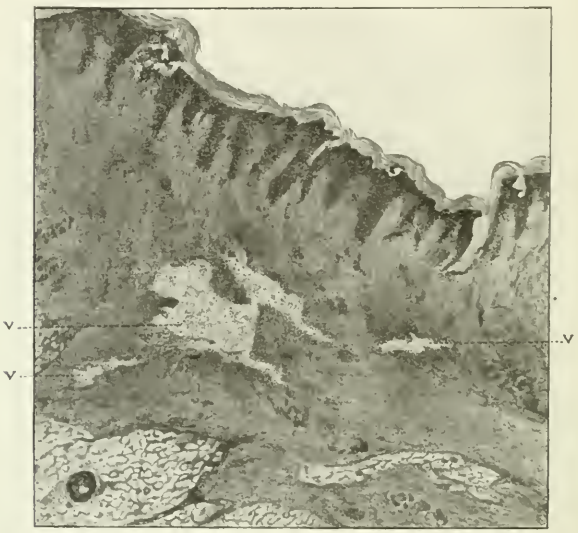
Fig. 4.

The forehead and cheeks are studied in an irregular manner by numerous milia of unusual size, with a tendency in certain localities to arrange themselves in groups. Upon compression, the characteristic sebaceous matter follows.

The cutaneous surface in close proximity to the anus has an appearance similar to that about the mouth, but existing in a more marked degree. There is a scaly area about the junction of the skin and mucous membrane, the outer edges of which embrace a number of oblong lesions formed of raised epidermis and containing fluid. The penis shows like changes about the meatus, extending backwards and encompassing one-third of the organ; the affected parts are scaly, the color is but a few shades darker than normal, and the borders are well defined, with a slight erythematous formation which proves their

recent origin. The back of the hands, the fingers and wrists are covered with large detached scales. The skin is greatly changed and very firm, but when moved the epidermis becomes grotesquely wrinkled. The affection stops abruptly and symmetrically just above the wrists. In appearance it resembles a superficial serpiginous syphilide, due to the elevation of the epidermis by the underlying fluid. Upon the affected area numer-

FIG. 5



ous vesicles are found having a very thin, translucent wall. The palms of the hands—the only part where discrete lesions are shown—are covered with bullæ. All of the finger nails are wanting. The bed of the nails is dry, quite soft and not sensitive to ordinary pressure, the merest trace of the matrix being left on the thumb. Over each knee is a large, irregular, infiltrated, elliptical patch, measuring six inches in diameter, the margin of which is composed of a number of elongated bullæ, while elsewhere the epidermis of the affected part is undergoing desquamation. The skin, directly over the patellæ, is practically normal; higher up, the surface is irregular, so that the margins of the entire ellipsoid

figure appear broken. On the right knee, below the patella and extending well towards the side, is a large irregular patch about six inches long and three wide, the border of which, covered with recently-formed lesions, is well defined, though with uneven edges. Upon the extensor surface of the ankle joint, over the annular ligament, is a desquamating patch about three inches square, affecting the locality where pressure is caused by the shoe, especially noticeable after considerable walking. The entire plantar surface, with the exception of the arch, bears evidence of the disease; the regions between the toes are likewise involved. The vesicles scattered over the affected area are few; the changes of the feet are the same as those characterizing the hands, except that the heels are more thickly covered with scales and the epidermis shows a more decided structure. The non-development of the nails is like that upon the fingers. The toenails are absent, except one on the right foot, which consists of a small, crumpled, horny mass.

The patient has been under my observation on three occasions only, and no essential difference has thus far been discovered in his condition. The eruptions always present the same unique features, with the exception of a diminution in the scaliness, and an increase in the inflammatory symptoms. In one instance the patient was the subject of an outbreak, which his parents assigned to the death of a neighbor of whom he was especially fond. However, they did not claim that all outbreaks were due to similar influences, but were satisfied that many of them were. Indeed they attribute the condition demonstrated by the accompanying photographs to unusual excitement. Numerous mechanical means, as rubbing, tapping, the application of heat and chemical irritants were tried without a reproduction of the blebs, although the subcutaneous injection of a fluid produced the condition on the following morning.

The Urinalysis: Amber color; specific gravity 1026; marked acid reaction; indican, slight indication; urea 2.5 per cent.; total solids 60 grammes per 1000 c.c.; uric acid normal. The sediment presents some epithelial cells, and many crystals of calcium oxalate.

The examination of blood made on two different occasions showed a slight increase in the number of eosinophile cells. Cultures from unbroken vesicles are always negative. Cover-glass preparations reveal the presence of leucocytes of the polymorphonuclear variety and occasionally an eosinophile cell, red corpuscles and epithelial cells, but never micro-organisms.

Thyroid extract and arsenic in increasing doses have been administered internally for more than a year. Local remedies and topical applications of every description have been faithfully employed, but

without favorable results. The simplest and blandest powder as a local dressing proved as efficacious as any of the various remedies used.

An examination of the sections made from a very early lesion which was clinically a minute vesicle, correspond histologically to the findings of Elliot, with whose paper upon this subject the profession is familiar, and also to those of Blumer, Colombini and others. As the investigation was restricted to the material supplied, it emphasized the fact that the vesicles were more deeply seated in the skin than usual. They were found to be formed between the rete malpighii and the papillary layers of the corium, their roof consisting of the normal layer of the stratum corneum and granulosum, together with the stratum mucosum which was more or less degenerated. The floor of these vesicles was composed of the papillary layer of the corium, the papillæ being bare and, in some places, elongated and distorted. There was evidence of edema and infiltration, the fluid undoubtedly having passed from the blood vessels, as they were swollen and greatly dilated. The contents of the bullæ were evidently a network from the remains of the rete cells and fibrin. There were present, also, a few eosinophilic and polymorphonuclear cells. The contents of other older blebs consisted of corpuscles, degenerated epithelial cells and leucocytes, with a small percentage of eosinophiles. Bacteria were practically absent. The blood vessels of the papillary layer of the corium were enlarged; many of them engorged with red corpuscles, producing an edema. In the reticulated structure, the leucocytes showed a tendency to group. These cells were apparently lymphocytes and the infiltration was more marked in the regions of the vesicles. No mast or plasma cells were discernible. The appendages were apparently normal, the elastic tissue was well developed, and no micro-organisms were found.

It was noticed that thin-walled bullæ, either small or large, filled with serum, rarely with blood, existed on various parts of the body, mostly at the extremities. On the whole, they were arranged symmetrically; their formation seemed to have been influenced by traumatism. They were subject to slow involution, which left an obstinate infiltration of the skin, causing a marked scaly condition, with an additional development of the blebs at the periphery. The circle thus formed was often broken, leaving a crescent outline, or a gyrate patch, the result of two more crescents coalescing. The inner side of the circle was usually infiltrated and scaly, while the outer border was always abrupt, and often defined by the formation of blebs; or there was merely an erythematous boundary about the mouth, as shown in the photograph. Another interesting fact is that the patient was born with a luxuriant growth of hair, which fell off upon the appearance of the

affection. This falling-off of the hair is a process which universally occurs at a fixed time, and should be strictly separated from the pathological process involved in so-called alopecia. The defect in the present case does not consist in the falling out of the hair, but in its deficient aftergrowth.

In considering the etiology of this particular case, the influence of heredity is a possible remote factor. Yet, strictly speaking, we have no right to assume a hereditary predisposition, although the blood relationship of his parents favors the inheritance of the pathological sequences. The falling-out of the hair, in addition to the characteristic lesions of the epidermolysis as described in other recorded cases, renders this case unusual. If the other skin lesions are left out of consideration, the case, etiologically, may be similar, so far as the hair and nail lesions are concerned, to dystrophia unguium et pilorium hereditaria, described by Dr. Chas. J. White, and to other cases included in his article. It would seem that the nail lesions are to be traced to the same causes which produce those of the hair, and are not due, as generally explained, to the pressure of a bleb formation about the root. There are evidently several general etiological factors at work in these cases, *viz*:—

First: A possible hereditary or congenital lack of resistance in the skin in connection with a poor trophic innervation.

Second: An increased irritability of afferent nerve endings in the skin, by means of which irritation, which ordinarily would have no effect, causes a local vaso-dilatation through the vaso-motor system.

Third: In connection with the previous factor, there may be a congenital lack of tone in the arterioles of the skin and mucous membranes, readily responding to vaso-dilator influences or local irritation by a dilatation of the vessels near the point of irritation and a leakage of fluid into the surrounding tissue.

Any of these etiological factors alone might be insufficient to cause the lesion, while a combination of all would be likely to produce it. In case of the hair and nail lesions, the trophic factor alone would seem to be present.

While the findings in this case do not conform in every particular to those previously reported, they most strikingly resemble those of the so-called dystrophic variety, which is distinguished from the typical epidermolysis bullosa hereditaria by a predilection for symmetry, more pronounced skin alterations, cicatrization, pigmentation, atrophy, the formation of milia within the diseased parts or in close proximity to them, degenerative changes in the nails and the frequent involvement of the mucous membranes—all of these manifestations, so characteristic of the variety involving secondary changes, were observed in the case

under consideration, but with these marked points of difference: a continuation of the lesion by the development of new blebs or vesicles at the periphery following the advent of each attack—a fact not before recorded; an association of lesions around the natural orifices of the body, especially the mouth, anus and meatus; a complete alteration in the structure of the entire hairy growth.

The only case of epidermolysis bullosa hereditaria which approximates this in uniqueness is that recorded by Hoffmann—the sole case on record where any hair changes are noticed, and this but a general thinning. There was also a distinctive localization of the lesions upon the extremities and occasionally within the buccal cavity, never upon the trunk, together with degeneration of the nails and slight atrophy of the skin. The affection, it is stated, manifested itself in the second year.

The more common type of the disease occurs in individuals with recognized hereditary tendencies, the bullæ always appearing wherever the skin is injured or irritated. The mucous membranes are seldom involved and only through special influences. The bullæ heal without cicatrization leaving a quickly-vanishing pigmentation. No permanent changes of the skin take place.

Luithlen states, in a recent article, that the typical disease has appeared only in Germany or in persons of German extraction. This is not in accord with the observations of physicians in this country.

I have at present in my care three cases in one family, all of which conform to the more common type. The mother of the patients is of Irish parentage but American born, and the father is all American.

Some authorities, in cases where secondary changes exist, materially complicate matters by placing those involving dystrophy of the nails in one class, and those of atrophy and cicatrization of the skin in another.

The conclusions of Elliot, Fox and Augagneur with reference to classification seem more acceptable. Secondary alterations occur in other skin affections which are not recognized as forming a specific class requiring a special term for their designation or diagnosis.

Attention is called to the fact that Bowen, whose opinion is always entitled to careful consideration, in an article with which you are all familiar, takes the ground that to the class of cases in which the one now discussed belongs, "*congenital bullous dermatitis* seems preferable to the term *epidermolysis bullosa*, as being less prejudicial to any further knowledge of the etiology."

For a correct understanding of this group of maladies we should not be overburdened with terms that create confusion, but should recognize the chief symptom involved—that of bulla formation, the result of irri-

tation, either by injury or pressure; not forgetting the fact that epidermolysis bullæ, regardless of any subsequent alterations which may appear in any particular case, should always be so classified.

The only argument which could by any possibility militate against this conclusion is the fact that the two types have never yet appeared in the same family.

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FOUR FORMS OF GENERALIZED EXFOLIATIVE DERMATITIS (ERYTHRODERMIES EXFOLIANTES, GENERALISEES, BESNIER).

By JOHN T. BOWEN, M.D.,
Boston.
Assistant Professor of Dermatology, Harvard University; Physician for Diseases of the Skin, Massachusetts General Hospital.

AS it has been my lot during the last few years to meet with an unusual number of cases of generalized exfoliative dermatitis, I have thought it worth while to describe four cases, illustrating different types of this obscure condition. It seems to me, in fault of all etiological aid, that there are sufficient points of dissimilarity to keep these forms clearly separated for the present. It certainly will not aid us in our endeavor to increase our knowledge, to consider them all as pityriasis rubra, without right of subdivision, as do the English, for there can be little or no doubt that different etiological agents are at work in these various forms.

Case I.—In December, 1900, I was consulted by a woman of twenty-seven, a resident and native of New Brunswick, who was then suffering from a third attack of general exfoliative dermatitis. I had considerable correspondence with her family physician, and from him learned that her first attack had come on five years previously, in November, after a period of anemia and neurasthenia that had lasted about a year. It had a sudden onset, beginning with distinct chills, nausea and vomiting, with a temperature for nearly three weeks of 101°-104°. It began upon the face as an intense erythema, accompanied by much edema, extending rapidly over the entire body, and on the fifth day exfoliation in large masses began, and continued at its maximum for three weeks, all the nails and hair being lost. The process then began to diminish slowly, and at the end of five months the skin had become nearly normal. It had not, however, regained its former texture, as there was a persistent roughness and dryness left. After this first attack there were several very slight and localized attacks of erythema, but nothing especially pronounced until the summer of 1900, five months before I saw her, when, without warning or known cause, there had been an almost exact repetition of the symptoms of five years previously, beginning as before, with chills, nausea and vomit-

ing, elevated temperature and an intense erythema of the face rapidly spreading to the rest of the body, and exfoliating in large masses, the whole surface of the palms and sole being thrown off at a time. This attack was much shorter than the first one and she had been well for three months until six weeks before she came to Boston for advice, when her third and present severe attack had manifested itself in the same way that the other two did, with initial chill and gastric disturbance and rise of temperature.

In this attack the nails have not been shed, but the hair has become very thin. When I first saw the patient she was covered with an absolutely universal scaling eruption, the scales at this stage being fine and branny, whereas at the beginning of the severe attacks they are always very large. The patient was small, but well nourished, and of fair complexion. The hair of the scalp and eyebrows is very thin and sparse. There is no glandular swelling and no abnormality of the mucous membranes.

At a second visit, some days later, there was considerable improvement. On close inspection there is seen to be a distinct dark pigmentation most marked upon the neck both in front and at the back, and extending down upon the back and abdomen. It is quite marked around the waist. Scattered over this pigmented area are small, round, apparently leucodermic spots, which are slightly scaling, less so than the surrounding pigmented portion, and which have in some instances an atrophic appearance. Further observation of the case showed that these white areas gradually increased in size and number as the scaling diminished, while the pigmentation also became less marked.

A year and a half after she was seen it was ascertained by letter that she had had three mild attacks lasting about three days each and characterized by chills, edema beginning on the face and extending over the whole body, followed by desquamation. The last attack was more severe, though of shorter duration than the two previous ones. During this attack the tongue was swollen so that it protruded from the mouth, but this symptom subsided after twenty-four hours. Almost all of her attacks had occurred during the summer or autumn. At this time there was still some mottled pigmentation of the trunk.

This patient declared that of late she had not been accustomed to perspire anywhere on the body except on her face. This dryness of the skin has been noted also by Brocq and Crocker. The latter considers this feature as a sequel rather than a cause, while Brocq holds the reverse opinion.

This case is an example of the recurrent desquamative scarlatiniform erythema, or dermatitis, which has been abundantly described.

especially by Féréol, Besnier and Brocq. In this case there could be no question of a confusion with scarlatina, except perhaps at the onset of an attack, when I did not see her, but all dermatologists will remember instances where they were much puzzled at first to distinguish this form of dermatitis from scarlet fever. The proof is positive that this form of exfoliative dermatitis may occur from the ingestion of drugs, such as mercury, quinine, etc., and, as is well known, Brocq and others have queried whether all cases may not be due to some such agent. It seems, however, pretty clearly demonstrated that no such association exists in a number of the cases. In the case reported the patient had at the time of the first outbreak been taking pills, the nature of which could not be determined. In succeeding outbreaks all possibility of medication as an etiological factor could be excluded. Besnier's position seems the most reasonable, *viz.*, that in certain predisposed persons many different causes, as medicaments, toxins, local irritants, etc., may determine this manifestation, and that the cause in the various attacks may not always be the same. This position finds its analogy in the well known susceptibility of the skin produced by poisoning with rhus or other cutaneous irritants, so that we may have from other slight causes recurrences of the exact type of the first attack.

We not infrequently see cases of a scarlatiniform erythema, sometimes more or less universal, often circumscribed, following surgical operations, sepsis, drugs or other causes. These are the scarlatinoid type of Besnier. In view of their frequency and that the form under discussion has many features quite distinct from them, it seems to me that this recurrent scarlatiniform eruption is better named generalized recurrent scarlatiniform *dermatitis* following Vidal and Leloir, Mario and Graham, rather than to place it amongst the erythemata. It should, however, be provisionally grouped with the universal desquamative affections, as it may be best studied from that standpoint.

Case II.—The patient was a clergyman, seventy-two years of age, who had always enjoyed good health and who had had no previous skin affection. There was a history of an attack of rheumatism and iritis some years previously. The attack had begun two weeks before I saw him, in December, 1900, on the face and head as a violent erythema with considerable edema, spreading rapidly to the rest of the body, so that at the time of my visit the eruption was absolutely universal, of a very intense red hue, and profusely scaling. The patient was a large, well-nourished, vigorous man. He had taken no medicine of any kind. The temperature was normal, the tongue clear, the urine normal. There was no itching and only moderate discomfort. At the apex there was a slight systolic murmur. On the scalp there was a tumor, somewhat ob-

scured by the scaling, which had been called a wen, and had existed for fifteen years. This tumor was excised later and found to be an epidermoid cancer. The scales were very large in size, separating from the legs in the form of sheets.

Two months later, February, 1901, the report was that the patient was slowly improving. The scales had now become very small and fine, the skin felt softer, and the erythema was not nearly so pronounced. There had lately appeared upon the chest and back, and to a less extent upon the limbs, quite a number of small white spots from the size of a pea to nearly that of a quarter of a dollar. They were not atrophic but stood out very sharply from the surrounding erythema, and were moderately scaling.

The patient's general health continued excellent, and he was soon able to go about and pursue his ordinary mode of life. The scaling and redness diminished very slowly. I saw him just a year after the beginning of the affection. It was found that the "white spots" that have been described had increased very much in size, so that the intervening hyperemic areas now appeared as the prominent spots, and not the white areas. The white areas were not scaling, but were slightly rough, while there was still a slight desquamation on the red spots. There was a slight general thickening of the skin on the face. It seemed evident that the white spots were produced by a disappearance of the hyperemia in those areas, with perhaps also a disappearance of pigment, a leucoderma, and that as the affection progressed toward recovery these areas increased peripherally. These "white spots" always had a convex margin, similar to that of vitiligo.

At the acme of the attack the hair was very much thinned, but was never wholly lost. The nails were lifted from their bed by the accumulation of horny material, but were never wholly lost.

This case belongs in the type of dermatitis exfoliativa Wilson, described by Brocq as "dermatite exfoliative généralisée," or "maladie d'Erasmus Wilson," although Wilson was not the first to observe the type, but only created the name dermatitis exfoliativa. It is not my purpose to discuss here the different symptoms of this form. In most instances, as is true of all forms of generalized desquamative dermatitis, the diagnosis is only rendered clear by the course and evolution of the cutaneous disturbance. Its claims to be separated from desquamative scarlatiniform erythema are not very imposing, nor can it often be distinguished clinically from the secondary desquamative dermatitis that is illustrated by the next case.

Case III.—The third case is that of a single woman of forty, who had had two previous attacks of intense dermatitis of the face and

hands which were considered to be due to poisoning by ivy, and were of that type. I saw her in September, 1899, when her head, arms, legs, and to some extent the trunk, were the seat of intense dermatitis, with much edema and very great erythema, but with scarcely any exudation. It was thought possible that ivy poisoning may have been responsible for this attack also, as the patient lived in the country and was in the habit of walking in the woods. After a few weeks this case, which began with the appearances of an artificial dermatitis, developed into a generalized exfoliative dermatitis. The patient continued in this state for over a year before there was any sign of improvement. After that there was a very gradual bettering with frequent relapses. When seen two and a half years from the beginning of the attack there was still some slight scaling and infiltration in places. The general health during the attack was never markedly affected, except what resulted from the affection of so large an area of skin. The nails were never lost, but were unevenly formed, opaque and covered with ridges. There were no other symptoms of importance, and never any elevation of temperature.

This case is thus briefly reported, as its type is familiar to all, and as it is of pretty common occurrence. It belongs to the form called by Besnier "erythrodermie exfoliante secondaire, accidentelle," which embraces the cases of generalized exfoliative dermatitis, following or developing from psoriasis, eczema, lichen planus, etc., or caused by the administration of a drug internally, as quinine, belladonna, etc., or by the action of an external agent, such as mercury. Should these so-called secondary exfoliating erythrodermata be accorded a separate place? Crocker declares that he has seen as fatal results from these secondary cases as from the others, and that a milder and shorter course is not a characteristic of them, as Brocq believes. It cannot be doubted that certain cases, as the one just reported, may be prolonged over years. Although I have seen a good many of these cases, I have never known one to have a fatal termination.

Case IV.—The last case is one of pure pityriasis rubra, of the Hebra type. It was described by me in the *St. Paul Medical Journal* in February, 1900.

The patient was an unmarried woman born in America of Irish parents, and twenty-five years old when the affection began. She had had no previous illness of importance, and the family history was negative. She was a strong looking and intelligent woman. When first seen the affection had just made its appearance and was confined to the face, and could not then be differentiated from an erythematous and scaling eczema. The skin was bright red, not infiltrated, and covered

with fine scales. There was no exudation. There was moderate pruritus. Otherwise the patient was perfectly healthy as far as could be determined.

I saw this patient at intervals of one or two weeks during the next few years. Treatment of various kinds seemed to have absolutely no effect on the process, which steadily progressed. Before long the scalp was entirely involved. Patches gradually appeared in the axillæ and on the chest, which increased or coalesced until at the end of a year from the time when she was first attacked, the entire skin was affected. No part ever became normal after it was once involved. There were no symptoms referable to the internal organs, nor any signs upon physical examination.

During the next four years, when I saw her at intervals, there was a slow progression of the disease. After the first year she was confined to the house on account of the difficulty in locomotion. The erythema became more pronounced and there was a very active and constant desquamation, mostly in the form of fine branny scales. There was never, from start to finish, the slightest sign of exudation. The palms and soles were covered with thick keratoses.

Treatment had practically no result. Thyroid extract was given for some time, and finally omitted on account of its depressing effect upon the heart. Arsenic was equally inefficient. Stimulating applications were not well borne, the greatest relief being afforded by those of a soothing nature. Various medicated baths were tried, but did not give especial relief.

Three years after the beginning of the affection, and two years before the patient's death, the hair began to fall from all parts of the body, until during the last months of life there was total alopecia. The nails became thickened and discolored and were finally reduced to brittle, formless stumps, loosely adherent to the nail-bed.

During the last year of the patient's life, there began to be a marked atrophy of the entire integument, with loss of almost all the subcutaneous fat. Three months before her death this atrophy had reached an advanced stage. Hitherto the suffering had not been great, as the internal organs performed their normal functions, and discomfort from the continual scaling and from the atrophy of the skin about the joints was the only thing complained of. Now there occurred occasional attacks of faintness, especially after eating, with flatulency and pain. There was also much restlessness and insomnia. At this time physical examination failed to detect any organic disturbance. The urine was normal. The heart's action was weak, but there was no sign of disease. A month before she died there was a fainting attack lasting

several hours, and after that the scaling, which had been continuous and excessive, suddenly ceased.

During the last month of her life the skin had shrunken so that the body looked about one-half its normal size. There was great ectropion and the lips were shrunken so that the teeth in front were fully exposed. The limbs could not be flexed. There were large bed sores on the back and over the trochanters. There was little or no scaling. The fainting attacks continued and there was much distress after taking simple nourishment. There was no glandular enlargement. Repeated examination failed to detect any internal complication, with the exception of weakness of the heart. She grew weaker rapidly and died of exhaustion, five years after the first appearance of the disease.

With regard to the question of tuberculosis, which has been found to accompany this affection so frequently, there were no signs of it at any time, in the case I am dealing with. It will be remembered that Jadassohn found tubercle bacilli in the glands in two of his cases, in one of which there were no other signs of tuberculosis.

Sellei, in a late communication, reports a case in which no symptoms of tuberculosis were observed, unless possibly a terminal diarrhea could be so regarded. It seems to me that the theory that we have in pityriasis rubra a condition which readily lends itself to inoculation with tuberculosis is far more probable than the assumption that the cutaneous changes are caused by the action of the bacillus, whether directly or indirectly. The rareness of this form may be seen from the fact that Jadassohn was able to collect only sixteen cases, to which he added two from his own observation and one doubtful one. Certainly the typical cases of this variety present sufficient characteristics to warrant their separation from the other types of recurrent scarlatiniform dermatitis or from those exfoliative processes secondary to drugs, or certain other cutaneous affections. The form of dermatitis exfoliativa Wilson would appear to me to have more points of similarity with Hebra's type, although I would by no means group them together. It is difficult to confute those who believe in a benign form of pityriasis rubra Hebræ, and granting that it may exist, it is hard to determine oftentimes where forms of the generalized exfoliative dermatitis of Wilson, with its rapid, acute onset and favorable termination end and pityriasis rubra Hebræ begins.

Clinical Notes.

A CASE OF ZOSTER OF THE ELEVENTH DORSAL ROOT FOLLOWED BY A GENERAL HERPETIC ERUPTION, PART OF WHICH WAS ALSO SEGMENTAL IN DISTRIBUTION.

By Charles J. Aldrich, M.D.,
Lecturer on Clinical Neurology and Anatomy of the Nervous System, College of Physicians and Surgeons, Cleveland; Neurologist to the Cleveland General Hospital and Dispensary; Neurologist to the City Hospital.

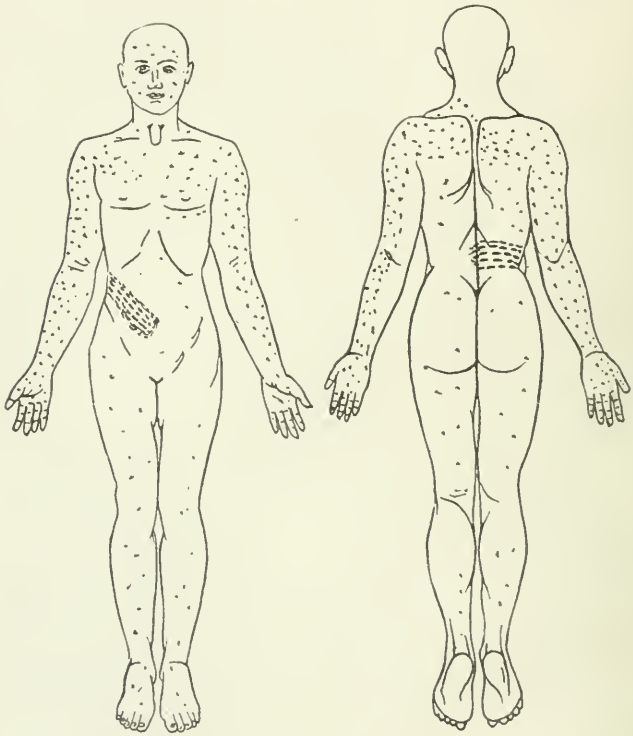
THE report of a typical case of herpes zoster possesses comparatively slight interest since such cases are not particularly uncommon. The violent forms, however, are not frequent but a case of herpes zoster accompanied by a general herpetic eruption is certainly most rare and will afford an apology for the record of the following case.

A. T. W., male, age 33, married, commercial traveler; seen in consultation with Dr. Pipes, of Cleveland, Aug. 18, 1901. He is a large powerful, athletic man, relates a good family history, and previously has never suffered any severe illness except gonorrhea, and a questionable inoculation of syphilis five years ago. He has a deep scar on the leg as a result of a wound received in our late war with Spain.

August 10th, he was in Minnesota and had been fishing and swimming in a lake; soon after this he began to feel a sensation of general malaise, chills, fever and aching pains throughout the body. August 13th, he was attacked with a severe pain in the back and loins in the area of the cutaneous distribution of the eleventh dorsal segment. The pain soon became atrocious and in twenty-four hours a rash appeared in that region. After this the pain seemed better but the rash became very tender to touch. When I was called to see him on August 18th, he was suffering a great deal of pain. The Doctor's diagnosis of herpes zoster was confirmed. It was located over the area shown in the cuts, of a bright pink color, confluent and exquisitely sensitive and painful.

He was taken to the Cleveland General Hospital and about August 20th, developed a typical herpetic eruption of very extensive distribu-

tion. The zones most marked are shown by the dotted lines in the cuts. There was a cervical distribution which was sufficiently marked to be accurately followed, but elsewhere it was diffuse and followed no



segmental lines. The second eruption was not preceded nor accompanied by any constitutional disorder, running the course of ordinary herpetic eruption and besides appearing on the surface of the body was also found in the conjunctival, buccal and labial surfaces.

612 Prospect St.

GONORRHEAL OPHTHALMIA, INFECTION FROM A KID GLOVE.

By Frederic Griffith, M.D., New York;
Surgeon, Bellevue Dispensary; Fellow of the New York Academy of Medicine.

THE point of interest in the following history is the mode of infection of the little patient. J., a boy aged eight years, while at play in the street found a lady's kid glove, which he put on and continued to wear in his play during the rest of the day. From rubbing his face the child's left eye became infected and at the end of twenty-four hours inflammation had closed the lids. Owing to ignorance of the seriousness of the affection upon the part of the boy's mother, home remedies were employed until too late to repair the damage. The child was brought to hospital, when it was found that ulceration and sloughing of the cornea had destroyed the sight. Treatment at this stage could do little save protecting the sound eye from further danger of contamination from the profuse purulent discharge coming from the infected orbit and in cleansing the infection. Later the shrunken, distorted organ was removed. The danger which the gonorrheal patient becomes to himself and to those with which he comes in contact must be ever borne in mind by the surgeon, the present instance serving to make this more forcibly impressive.

Book Reviews.

Cutaneous Blastomycosis. F. H. MONTGOMERY. Reprinted from the *Journal of American Medical Association,* June 7, 1902.

Die Blastomykose. A. BUSHKE. Heft 10, Abt. D H., Derm. u. Syph. Bibliotheca Medica. Stuttgart: Erwin Nagele. 1902.

These monographs with Méneau's review in the *Annals de Derm. et de Syph.*, June, 1902, put the subject of cutaneous blastomycosis before the readers of three languages in able and conclusive fashion. Of the three, Montgomery's is most important for it contains his and Dr. Hyde's personal observations on no less than 14 cases in human beings, an extraordinary number considering that the total for the world is 40 odd. Most of their cases, the JOURNAL readers are already familiar with since they were published here first. There is a striking feature in the photographs, the similarity which exists in the clinical aspect of the different cases.

Bushke who has had a case of his own, has published a much more pretentious work illustrated by colored plates of the blastomyces and its lesions chiefly (one clinical photo.). He includes animal blastomycosis also, thus swelling the bibliography to enormous dimensions. Both cultures and clinical appearance give a different impression from our American cases.

Montgomery brings a scathing charge against Ricketts, a sometime laboratory assistant, who published an article in the *Journal of Medical Research* which he entitled "Oidomycosis," a reform in terminology, by the way, which does not reform. Montgomery says he made unauthorized use of his cases, some of which he did not see and on which he did no work, that he appropriated certain illustrations without leave or with the scantiest recognition and that the entire publication was premature. It is hard that investigators and editors cannot be protected against this sort of thing.

There is no need to review Blastomycosis Cutis in these pages where so many of the cases have been reported. Bushke's work on animals is in a measure new to us.

General Paresis. ROBERT HOWLAND CHASE, M.D. P. Blakiston's Son & Co. Philadelphia. 1902.

A book of 291 pages in which the author seeks to convey to the general practitioner the knowledge by which he will be able to make a diagnosis of general paresis in its early stages. He follows Mickle in dividing general paresis into four periods. (1) A prodromal stage, or period of moral and mental alteration; (2) a stage of decided mental alienation, or of dementia only; (3) a stage of chronic mental disorder; (4) a stage of fatuity.

After discussing very briefly each stage, he gives the history of cases as nearly as possible, representing these different stages. Many histories are thus given, but in most cases important details are missing.

He next takes up the varieties of general paresis, mentioning those described by Folsom, B. Lewis Sankey, M. Baillarger, Voisin, Mickle, Meynert and others, expressing no opinion of his own, but apparently accepting the following types: (1) The galloping form. (2) The double form. (3) General pare-

sis of the melancholic form. (4) Spinal general paresis. (5) General paresis with simple progressive dementia. (6) Juvenile general paresis. (7) General paresis in woman.

Following brief remarks about these varieties he gave a few histories of cases representing each.

The particular symptomatology is next discussed. Here also cases are reported illustrating the different symptoms.

A short chapter is given to Differential Diagnosis.

The chapter on Etiology contains quotations and histories of cases taken from other writers. The author does not commit himself. Thus in the same way chapters are given to prognosis, pathology and treatment of the disease.

The Author's own views are little in evidence, the opinions and cases are mostly quotations from other authors, and many of the histories themselves are unsatisfactory. For a general practitioner the book might have been smaller and still convey to him as much as does this one. For a specialist nothing new is contained in it. M. G. Schlapp.

The Operations of Surgery. W. H. A. Jacobson, M.Ch. Oxon., F.R.C.S. Fourth edition, Revised, Enlarged and Improved. Two Volumes. Volume I., Operations on the Upper Extremity; Operations on the Head and Neck; Operations on the Thorax. Volume II., Operations on the Abdomen; Operations on the Lower Extremity; Operations on the Vertebral Column. P. Blakiston's Son & Co., Philadelphia, 1902.

The fourth edition of this well-known book is well up to date and accomplishes most admirably the purpose intended by its author, namely, furnishing to advanced students and hospital internes a work upon operative surgery sufficiently comprehensive in scope and full in detail.

The different regions of the body are taken up in order. A brief review of the surgical anatomy is first given and a detailed account of the different operations follows. The plates are often admirable and the text is clear, terse, and interesting.

Much discrimination has been shown in selecting the modern operative methods most in vogue and in leaving out the discussion of novel and untried procedures.

The book is generally well in line with modern surgical teaching in this country, and as the authors have borrowed freely from the plates and descriptions of French, German and American works, it represents very well and in concise form the best methods of modern operative surgery.

It is a book which will be valuable alike to the student and the practitioner, and should be classed among the best works upon the subject. Hotchkiss.

Special Pathology. Alfred Edward Thayer, M.D. Quiz Compends, No. 18. Philadelphia: P. Blakiston's Son & Co., 1902.

This is the companion volume to the General Pathology reviewed in the last issue. Taken as a whole, it is as satisfactory as a little book on a tremendous subject can be, both from the teacher's and the student's standpoint, better than the preceeding part. It has some features which are not very common in any compend on pathology, the best of them being a rather elaborate discussion of the gross appearance of diseased organs. From the average textbook, one would imagine that all pathology is to be read by the microscope from

slides showing bits of tissue stained red and blue. All medicine has or should have its basis in autopsy findings. A serious omission is that of a chapter on diseases of the nervous system but is readily understandable when one considers how successful the neuropathologist has become in weaving, from shreds of topography and half-forgotten bits of general pathology, a veil of esoteric mystery about his specialty. It is no place now for a self-respecting pathologist. The blood should have a longer consideration than ten of these little pages allow. What is there is very well; what is omitted is more than a little. Malformations might very well be left to special treatises and the space used for pure pathology in the next edition. The kidney chapter where faults crop out usually like weeds is good apparently because it does not wander very far from Delafield's teaching except in the terms which are not confusing. There are minor omissions here and there as of Shiga's bacillus in dysentery and the replacement theory in cardiac and hepatic fibrosis which it were well even for a student to know but something must be omitted and the author's choice is final.

There is a chapter on the histopathology of the skin. It contains some of the things we know about and others of which we think the same. As I wrote it myself, I shall dismiss it with the comment of one of my students—that "it takes too much for granted." J. C. J.

Physician's Visiting List for 1903-4. Philadelphia: P. Blakiston & Co.

This is the fifty-second reprint of the List, a longer career of usefulness now than most of us are likely to have. The effort for improvement has added some pages on incompatibility of all sorts and immediate treatment of poisoning, both likely to be of service in emergency. The familiar features remain.

Les Injections Epidurales par Ponction du Canal Sacré et leurs Applications dans les Maladies des Voies Urinaires. DR. FERNAND CATHELIN, J. B. Baillière et Fils, Paris, 1902.

The title practically tells the whole story: whether or not this new method of administering therapeutic agents has opened up a new field for investigation, the book is very suggestive and most interesting.

The author begins with the history of these methods, and names Corning as the first to work out spinal anesthesia. He then goes into the history and manner in which this particular method, namely, the injection of different substances, mainly, however, normal serum into the spinal canal by way of the sacral vertebra was developed, and the disorders for which it has been used. It would seem that its greatest use aside from that of quelling pain has been in the various forms of enuresis and bladder disturbances. G. K. S.

Genito-Urinary and Venereal Diseases. LOUIS E. SCHMIDT, M.Sc., M.D. The Medical Epitome Series. V. C. Pedersen, M.D., Editor. Lea Bros. & Co., Philadelphia and New York, 1902.

While as a rule so-called quiz-compends have always seemed to us a form of medical work to be frowned upon and discouraged, we are pleased to note the thoroughness with which the author has covered his subject and can recommend the work to those who are looking for this class of book. G. K. S.

Society Transactions.

NEW YORK ACADEMY OF MEDICINE.

Section on Genito-Urinary Surgery.

Wednesday Evening, October 13, 1902.

John Van der Poel, M.D., *Chairman.*

Urine Separator (Diviseur Vesical Gradue), of Dr. F. Cathelin, Paris.—Dr. John Van der Poel.

I had expected this evening that one of our members would also show the Urine Separator of Dr. Luys of Paris, which was brought out about two years ago, unfortunately the Doctor has not brought it this evening. I perhaps ought to apologize for showing the Cathelin instrument, having myself used it so little, though it was demonstrated to me by Dr. Cathelin himself, and I have used it myself with good result. In the first place it is an extremely simple instrument and one that can be used by almost any operator, requiring but little technical knowledge beyond that of being able to wash out a bladder, and perhaps being able to pass a lithorite. Beyond that it is simple enough. It consists in the first place of a hollow tube in the shape of a lithtrite, corresponding to a No. 25 French. In the center of this tube is a flat piston, upon the end of which is attached a membrane which separates the bladder into the lateral chambers. Upon the sides of the tube are two openings, into which, and through which, pass two, what would correspond to what we know as, urethral catheters. The preparation of the instrument is as follows: The sterilization in the first place can be done by ordinary boiling, with everything except naturally the gum silk catheters, which are sterilized by formaldehyde. The whole box can be sterilized or simply the instrument itself. After sterilization, it should be prepared by passing one of the catheters through the canal at the side until it comes to the opening at the other end; likewise that of that opposite side. The second step is the injection of a few drops of liquid through the catheters to see that they are permeable. Next attach the membrane or diaphragm to the distal end of the instrument, where it fits into a catch on the end of the piston, and is fastened by means of a little tack, held in place by a spring. The membrane being attached and in position, it should then be oiled with sterilized oil or lubrichondrine and then piston withdrawn until it (the membrane) entirely disappears within the shaft. The preparation of the patient is the same as for any cystopic examination, that is, the bladder is washed with one of the various solutions at our disposal, after which it is necessary to find out the capacity of the bladder (that is, not its greatest capacity, but the point where the patient first desires to micturate). The instrument has been used by Dr. Cathelin with a patient who had a capacity of about 18 grammes, and was kept *in situ* for 14 minutes. This is the smallest one on record, I think. It can be used with almost any sized bladder, but I think in extremely large or sacculated ones it might not be applicable. After deter-

mining the capacity of the bladder, then inject 10 c.c. of our sterile fluid, in order to afterwards start siphonage. The instrument is then passed and the catheters introduced, i. e. protruded at the distal end into the sides and lower part of the bladder. The distance which they should be introduced depends upon the capacity of the bladder. If it is one of 100 grammes they should project 2 ctm.; if 200 grammes, 4 ctm.; if 300 grammes then 6 ctm., which distance can be measured by markings on their proximal end. After introduction, the beak of the instrument is brought back snugly against the symphisis pubis, which brings the inferior portion with part of the membrane into the posterior urethra, so that part of the membrane lies in and divides the posterior urethra as it does the bladder. After it is drawn against the symphisis pubis, then protrude the membrane corresponding to the number of grammes which the bladder will hold, which are marked upon the proximal end of the piston. It is then brought upwards slightly, not being left exactly in a horizontal position, so that the membrane will fit better into the bladder floor. The edge of the membrane is composed of a thin wire, which prevents it from collapsing. The fluid which we have injected will then begin to flow easily and rapidly, but if they do not run immediately it is a very simple matter to inject a few drops at the end of either one, to start the flow. The usual sitting is not over 30 minutes, allowing eight to ten minutes for getting it in working order. The urines are then collected into the glasses or tubes, the outer end of the instrument being held firm and resting on a stand, consisting of the lid of the box, into which is secured a sliding rod, for male or female patients. The patient is prone upon the table, with head slightly raised, and thighs separated. There are bladders, of course, where it would not be applicable, but there is no one instrument so far that will answer in all cases. There is no pushing up (as in the segregator) of the wall of the rectum, and no forming of a partition in the bladder, except by the membrane which is introduced. The removal is simple. First withdraw the catheters, and then the membrane, after which release the instrument as one does a steel sound.

DISCUSSION.

DR. CHAS. L. GIBSON said he was sorry that he did not bring the segregater of Dr. Luys. He believed it to be a simpler instrument than the one presented, shaped like a lithotrite, with a diaphragm operated by a screw at the handle, and a rubber bridge, which alone forms the division of the bladder. It can be worked only in an empty bladder. There are no catheters attached and the bladder-urine flows directly into the openings on either side of the diaphragm. From that standpoint he thought it was superior to this instrument although the one presented seemed more effectual. It did not exclude bladder-contamination which was a point quite fatal in all these instruments. It might be wisest to employ all of them a control by injecting on one side some methyl-blue, to ascertain if there is leakage on the other side.

Specimen of Vesical Calculus.—DR. SWINBURNE said he had a case last summer that presented some features of interest. A calculus, rather soft, was removed by litholapaxy. The method by which he discovered that the patient had a calculus he thought might be of interest to the section. The patient had frequency in urination, the urine was cloudy, there was pain at the end of urination, and no venereal history was given. At the clinic he had so many patients with prostatic trouble presenting, similar symptoms that he thought that possibly prostatic trouble

might exist in this instance. Examination by the rectum revealed a condition which exactly resembled an enlarged prostate, but presure with the finger seemed to cause one-half the prostate to disappear. It seemed to him as if a calculus was wedged behind the prostate when the bladder emptied itself, and to the finger its rectal surface was continuous with that of the prostate. A searcher introduced into the bladder at once revealed a stone. This patient had only been in this country about two months and he had had the pain about six months. Another feature of interest in this case was the question whether litholapaxy or a cutting operation was better. At first he believed that the stone might be contained in a cavity behind the prostate, but when fluid was introduced into the bladder for cystoscopic examination the stone was shown resting on a perfectly flat surface, and it seemed to him a clear case for the operation of litholapaxy. The operation was done in a tenement-house, on the ground floor, in a dark room, and under the influence of chloroform. After introducing the lithotrite and catching the stone between the jaws there followed a sensation exactly like that when the stone slips from the grasp of the instrument. Again he caught the stone, and thought he had caught a smaller end of it, and on closing the jaws thought it had again slipped. The third attempt was followed by a similar result, and then he could not find the stone. After ineffectual search for the stone, the evacuator, when introduced, brought away all the fragments. The stone had been crushed by three movements of the lithotrite. Such an experience had never occurred to him before. Of course it was due to the softness of the stone. The operation was performed last August, and the patient is in good condition to-day.

The sensation described of pressing the calculus into the cavity of the bladder from where it seemed wedged behind the prostate was verified four days in succession. It occurred when the bladder was empty, and made him think it had formed a pocket for itself behind the prostate. The cystoscope, however, showed no sacculation whatever.

A Case of Rectal Gonorrhea.—DR. GRIFFITH presented the history of the result of pederastic acts upon the part of a patient, and it gave a glimpse of a form of male prostitution as carried out in this city, and showed furthermore the precautions which seemed necessary, as had been shown in the recitals of Kraft-Ebing, and which were taken in this case to prevent blackmailing of those who participate in this form of sexual indulgence. J. M., a male twenty years old, a driver by occupation, had always been healthy and possessed a well-formed body. Said he had indulged in sexual intercourse very frequently. He came for treatment for a violent, creamy, yellow discharge from his penis which had lasted three days. His statement of the source of his trouble was that seven nights before, while lounging on a corner, he was approached by an affable stranger who invited him to visit a saloon. While not in the habit of indulging in intoxicants, he accompanied his new-found friend and partook of a glass of beer. Entering into conversation, he was invited and accepted an invitation to take a trip to Philadelphia. Although himself without money, his new friend appeared to have plenty of means. The pair journeyed to Philadelphia, and late the same evening secured a room at an expensive hotel, and the end of the proceeding was that M. had intercourse per rectum three separate times during the remaining hours of the night. The two returned to this city early the next day where M.'s friend, before losing himself in the crowd, gave him $5. M. described his erstwhile friend from his build and by his actions as being a "sissy." He had noted also that during penetration the man's buttocks

were wet, and that his anus was patulous. M.'s subsequent symptoms were those of a typical gonorrhea, with the demonstration of gonococci.

A Case of Ruptured Kidney.—DR. RAMON GUITERAS reported the case of a laborer, 29 years old, who was brought to the hospital suffering from a pain in the right side which he said existed for several weeks. Examination showed a cachetic individual, thin, emaciated, with the thigh slightly flexed upon the abdomen. On the right lumbar region was a mass filling the entire iliocostal space behind and extending well over towards the median line in front. This was ill defined having no distinct contour as would have been the case of a large kidney, and was hard and indurated to the touch. No fluctuation could be felt. The urine was of a specific gravity of 1,026, high colored, thick, contained a slight trace of albumen, a large amount of pus, few blood cells, bladder and renal epithelia, granular epithelial and pus casts, uric acid crystals. The patient's condition was very bad. He had been for some time in a workman's hut in an adjoining village. His pulse was 130, temperature 102, respiration 28. He was brought to the operating room, quickly anesthetized, and a lumbar incision made. This was followed by a gush of pus estimated between one and two pints. The finger inserted into the pus cavity found a large space in the loin not extending to the pelvis or above the abdominal cavity. The kidney could be felt somewhat enlarged, sclerosed, and in the posterior aspect a hole was found into which the finger inserted felt a sharp foreign body which was loosened and removed. This proved to be a calculus an inch and a quarter long and one half an inch in width. The wound was quickly packed, the incision made smaller by two ligatures through the abdominal wall above, the drain coming out below. The patient was discharged from the hospital. One month later he returned in a condition worse than before with his leg and thigh more flexed. He hobbled to his bed with his hand resting on his thigh for support, and his body bent towards that thigh. The woand was still closed, there was tumor in the iliac region, and there seemed to be deep seated swelling in the front of the thigh extending down midway to the knee. Th patient was again anesthetized, the old wound opened from which some pus escaped. A counter opening was made in the iliac region which communicated with the lumbar opening. Another opening was made in the anterior part of the thigh midway to the knee and more pus was evacuated. Drains were inserted from the lower to the iliac region and from the iliac to the lumbar. The kidney was densely bound down by adhesions and it was thought better to wait to see the result of the operation before attempting possibly a nephrectomy. The lower sinuses closed only one remaining in the lumbar region. The patient left the hospital to recuperate during the summer and we were to notify him when to come in for a nephrectomy. He now cannot be found. I am sorry that I have not the case to present, or the pictures to show that I expected to have this evening.

DR. JAMES PEDERSEN—I have seen one similar case. The occurrence took place during intoxication of the patient.

A New Method of Finding the Urethra in External Urethrotomy.—DR. CHAS. L. GIBSON read this paper. The modification of the operative technic was intended to give an immediate and certain entrance to the deep urethra in strictures not permitting the introduction of the ordinary guide. As the result of repeated trial upon the cadaver he found that sharp traction on the prostate downward and somewhat backward will make taut the deep urethra to a degree that makes its recognition unmistakable. With the patient in the lithotomy-posi-

tion, the rectum is thoroughly washed out, a rectum speculum introduced, and the prostate transfixed laterally from the rectum by a large, sharp hook. A median perineal section is then performed. The left forefinger is introduced into the wound, and as an assistant tugs gently on the hook one readily receives the sensation of transmitted tension of the urethra. The surgeon then directs the bistoury into that portion of the deep urethra which has been made prominent, the probe-pointed director readily glides into the lumen of the urethra, and following it the small metal catheter will demonstrate the successful entrance into the bladder.

DISCUSSION.

DR. LILIENTHAL said that although he had had considerable genito-urinary surgery, he could not agree with Dr. Gibson when he said that the operation of perineal urethrotomy without a guide is a simple one in any case. He thought that any improvement in technic which will render the operation more certain, and especially more rapid, is very much to be desired. He thought many lives have been lost by too long perseverence by the surgeon in trying to reach the goal through the perineal wound only, and in fact he had lately never hesitated in cases in which the patient's condition was poor and in which the search promised to be tedious, to perform suprapubic cystotomy and retrograde catheterization. He thought Dr. Gibson's idea an excellent one to save making another wound. It seemed to him that if we have a wide perineal opening and make our dissection anterior to the rectum and can feel the prostate with the finger, that the same procedure could be employed through the perineal wound instead of through the rectum without the possible chance of infecting the prostate through the rectum. He thought we owed Dr. Gibson thanks for calling our attention to such a very simple method.

DR. J. PEDERSEN thought that Dr. Gibson deserved great credit not only for the novelty of his suggestion, but also for having proven its feasibility on the cadaver and its value clinically to his satisfaction before reporting it. In regard to the suggestion made by Dr. Lilienthal, that the hook be inserted and traction made by way of the perineal wound, it occurred to him to say that the time required to dissect down upon the prostate in order to transfix it would more than counterbalance the very slight risk of using the hook by way of the rectum, as one of the prime results of Dr. Gibson's technic is the saving of time; furthermore, that while dissecting down upon the prostate for the purpose of transfixing it, we could just as easily find the urethra at the apex of the prostate.

DR. GIBSON said that in the ordinary urethrotomy through a vertico-median section he had also attempted to produce traction upon the prostate, but never with satisfactory results, never approaching in effectiveness the other method. One must get a good purchase upon the prostate, fix it and manipulate it. He had never tried the transverse incision for such cases, as it involves a rather extensive dissection of the perineum.

Repair of Complete Defects of the Male Urethra.—DR. A. A. BERG said that the urethra possessed two attributes that are of importance in the consideration of plastic surgery upon it; namely (1) its considerable elasticity, especially in its penile portion, in virtue of which it can be distracted, so as to supply a defect in its continuity between two and three cm. in extent, and (2) its power of almost complete regeneration from a stump. The parts of the urethra that re-

generate are the mucosa and cavernous body. Juglianni demonstrated that a small stump of the urethra implanted into one end of an artificial canal made under the skin will grow and gradually line the interior of the entire canal. The types of plastic operations, to supply defects, and the indications for their employment are:

1. The method of mobilization of the urethral stumps; stretching them until the ends meet and uniting them in this position by end to end suture. It is especially applicable to small defects in the penile urethra; *e.g.* hypospadias, but it can be also employed in the membranous portion of the canal. Its limitations are (*a*) large defects, exceeding 2 to 3 cm. in extent; (*b*) lack of mobility of the urethral ends owing to cicatricial tissues, or (*c*) too great friability of the urethral ends from preceding inflammation.

2. The method by which defects, partial or complete, are healed by the regeneration of the urethra from its ends (Guyon's operation). This procedure has a wider range of applicability, its only limitations being too extensive destruction of the soft parts overlying the defect, or too extensive cicatrization of these tissues.

3. The method of forming a new canal by grafting skin or mucous membrane, either from the immediate vicinity or from other parts of the body, upon the site of the defect and then uniting such grafts to the proximal and distal ends of the urethral wall. This operation has but a limited range of applicability, and is to be employed only where the others are contra-indicated. In the original paper, the technic of the various operations is minutely detailed. The author details two of his cases of large defects of the perineal urethra, due to extensive sloughing, in which the Guyon operation was employed, with complete restoration "ad integrum."

DISCUSSION.

DR. JAMES PEDERSEN said that Dr. Berg's paper was most interesting; particularly so because defects in the perineal portion of the urethra are generally held, he believed, to take care of themselves, so to speak, if treated after the manner of an ordinary perineal urethrotomy. Of course there are exceptions to this rule, as would seem to have been the case in the cases cited by Dr. Berg. He wished that Dr. Berg had detailed one or more cases of defect in the pendulous urethra, where defects are more difficult to repair. He knew that he had labored industriously over one or two cases of defect in the middle portion of the pendulous urethra. Defects near the meatus are easily repaired, provided there is integument enough to form a good flap. He had secured very satisfactory results in two cases in which there was quite an extensive defect on a level with the corona. Last winter, in a case of defect at the peno-scrotal angle, he secured a perfect result by using a fold of scrotum for the flap. He added that in the first two cases quoted, perineal drainage was maintained during the healing, and that in the case last mentioned advantage was taken of a necessary epicystotomy.

DR. LILIENTHAL had found it advantageous in cases of this sort not to close the skin by suture, not to close the skin opening at all, for that matter, for the following reason: He had in one case the misfortune to have a leak between the sutures and this leak became septic. There was a complete giving way, owing to abscess, of the entire line of union, and a dissection of the subcutaneous tissues by pus. If the line of suture of the urethra is covered by rubber tissue, then

gauze, and bandaged firmly, even if there is a little leak the urine will find its way out. There will be no tension, no dissection, and during granulation this opening will close spontaneously, whereas if the skin is sutured, suppuration takes place between the skin and the underlying sutures and the entire wound will reopen. Therefore in these cases, as in a number of others, he does not close the skin wound; you cannot be perfectly sure of your asepsis.

Dr. Van der Poel was inclined to agree with Dr. Lilienthal, and Dr. Gibson. I had had a similar experience to Dr. Lilienthal, and would prefer simply to close the urethra, at the beginning and allow the granulation to complete the filling in, when in case a few drops of urine do leak out, they will do no harm.

He would be very loath to close in a fresh rupture of the urethra completely, and would treat it somewhat like a case of external urethrotomy, until the sinuses close.

Dr. A. A. Berg closed the discussion.

As regards the immediate suture of the two urethral ends, the advisability would depend very much upon the condition of the parts at the time of the primary operation. In infected sloughing tissues it could scarcely be considered as the best procedure. In clean tissues it would be apt to be followed by a good result; likewise where the urethral ends are not too far separated or where the rupture is incomplete.

As to dealing with a partially or completely lacerated urethra, in which there is a loss of substance of the urethral wall, as with an external urethrotomy, it must be borne in mind, that after even a simple, external urethrotomy for stricture, where there is no loss of substance, but merely a linear division of one wall, a perineal urethral fistula at times persists. This is due to the mucous membrane of the urethral canal growing out and lining the sides of the perineal wound. There is at present in the wards of Mt. Sinai Hospital such a case; a young man upon whom an external urethrotomy for stricture was performed in one of the City Hospitals.

To heal such a mucous fistula it is necessary to dissect out and remove all the adventitious mucosa, and close the urethra by suture.

Some cases of partial rupture will heal when treated after the method of an external urethrotomy; yet there are many more in which there will be no tendency to a spontaneous closure of the defect; as in my second case.

As regards complete closure of the perineal wound, Guyon never had any serious suppuration of the stitch holes. In one of my cases the stitch hole infection did not interfere with healing. If the skin is left open, a secondary infection of the deep sutures may occur. The ultimate result in a majority of the cases will probably be better if the wound is completely closed.

Defects in the penile urethra do not belong to those for which the Guyon operation is advisable. They are better treated by mobilization and suture of the urethral stumps.

NEW YORK DERMATOLOGICAL SOCIETY.

305th Regular Meeting, September 23, 1902.

OSCAR H. HOLDER, M.D., *President.*

A Case of Iodide Eruption Papulo-Vesicular, General.—Presented by DR S. SHERWELL.

E. L., act. 40, U. S., married, came to office June 19th with 5 or 6 small vesicles one or two of which were ruptured around corona glandis. Herpes progenitali of typical variety—dusted him lightly at time with calomel, told him to repeat it once or twice a day, keep clean and report, which he did. On 24th saw him again. All had disappeared, not a reddening or scar left. He had been exposed once or twice within a fortnight previously, but had taken all precautions apparently. On or about 24th of July did not even make entry in books, reappeared at office, examined him naked; no eruption, in perfect health in every way. On 3d of August came in with diarrhea and with a bubonic enlargement in *left* groin, inflammatory in character; the rest of the glands not swollen, and no adenopathy on right groin. Examined crural canal on side affected and found slight tendency to patency of ring. Enough with that straining, etc., to cause irritation of canal and parts adjacent. Gave him lotion of mildest iod. tinct. and KI. to apply. On 10th of August bubonic enlargement quite marked and deep fluctuation, a slight eczema on parts where lotion had been applied and a streak across upper breast, as if he had wiped or scratched his fingers across it. Called in Prof. H. H. Morton, as he was terribly syphilophobic, who without a moment's hesitation negatived the idea of syphilis as to the eruption, and recommended ablation of the glands of left groin as the quickest way to do away with trouble. He then left me and consulted another physician, who treated with antiphlogistine till August 27. Then opened and evacuated pus. *Had no eruption, as now appears, up to that time.* He had previously (a few days) put him on doses of Pot. Iod., 5 grn. doses, a few days after he had a bad (very) coryza and the eruption of the papulo-vesicular character commenced to appear. After rather more than two weeks of the Iod. Pot. treatment, it was supplemented by 4 $\frac{1}{4}$ gr. tablets of Hydrarg. Id. under which the eruption has become worse. Had an inflammatory tonsillitis as well, which is getting better without treatment since stopping KI.

DR. H. G. KLOTZ said that it was remarkable that such a severe eruption should have developed in this short time.

DR. J. A. FORDYCE said that many of these cases were mistaken by the general practitioner for papulo-pustular syphilides, and were treated, in consequence, with mercurials and iodides, with the result that they were made worse. Such a mistake was very easily made.

DR. C. W. ALLEN agreed with the diagnosis and indorsed the remarks that had been made. He had seen a similar eruption produced by self-medication with certain preparations of so-called sarsaparilla. In the presence of an eruption of this kind it was possible for a quack to reap quite a harvest by preying upon the fears of the patient.

DR. J. C. JOHNSTON said that fifteen grains of iodide were sufficient, according to his experience, to produce such an eruption. Last spring he had

had two patients for whom he had prescribed fifteen grains of iodide of potassium, three times a day. One took two and the other six doses. Both of them immediately developed a very sore throat, a marked coryza and congestion of the eyes. Examination of the interior of the latter showed all of the vessels congested and even the optic nerve. One of the patients did not recover for thirty days although he had only taken thirty drops of a saturated solution of iodide.

DR. SHERWELL said that on two or three occasions he had seen a patient in hospital presenting such an eruption that smallpox was suspected, and the Board of Health officials had been called in. This had followed only a very moderate dosage of the iodide. He had known a very few grains of bromide would likewise produce a marked eruption, though the lesions were usually flatter and broader than the iodide dermatitis.

A Case of Epithelioma Treated by the X-Ray.—Presented by DR. C. W. ALLEN.

The patient was man who had been referred to him by Dr. Holder at the last meeting of the society. The man had had an extensive carcinoma on the wrist for twenty years, which had exposed the bones and tendons. Since last presented to the Society the patient had been treated by the X-ray and about two-thirds had healed.

DR. GEORGE T. JACKSON said that the result was certainly very brilliant, and better than could have been produced by any other means at our command.

DR. JOHNSTON suggested that this patient be photographed at successive stages, and the photographs reproduced when the case was published for the sake of the "doubting Thomases."

DR. FORDYCE suggested that it might also be well to fortify the diagnosis by having a microscopical examination made of sections of the growth. Such sections were often instructive when taken both before and after X-ray treatment.

DR. I. DYER of New Orleans said he believed that the X-ray was curative in epitheliomata characterized by granulomatous tissue.

DR. FOX said that he had had an opportunity of watching the case, and while the result was brilliant he could not accept the statement that such a result could not have been obtained by any other method. He thought it probable that the same result would have followed the use of liquid air, though he did not mean to say that this was as good or better than the X-ray. He would also say that the same result could be obtained by thorough curetting.

DR. O. H. HOLDER said that when he had first seen this patient he had probed around and found the tendons all exposed so that the use of the curette or of liquid air would have probably aggravated the condition. The base of the growth was apparently down among the muscles, tendons and bones.

DR. JOHNSTON remarked that in such cases the rule among surgeons was to amputate the limb.

DR. ALLEN said he now had under X-ray treatment a patient who had been treated by the liquid air until nothing more could be accomplished with it, yet decided improvement was taking place under the X-ray. He did not think the liquid air could be compared with the X-ray.

A Case of Prurigo.—Presented by DR. CHARLES T. DADE.

The patient was a baby of two years, who had had a mild form of prurigo almost constantly since the age of six months.

DR. KLOTZ said that this seemed to be a genuine example of prurigo. He

had presented a number of mild cases some years ago. One of the children, who was conceded to have a mild prurigo, had been seen by him some years later, and was found to be cured. In a typical case in a male adult, which had developed in Europe, and which came under observation for some other affection, the conditions had apparently not improved, and the patient did not care to be treated for it again.

DR. FORDYCE accepted the diagnosis.

DR. ALLEN said he did not think prurigo was nearly so uncommon in this country as it had been thought to be ten or fifteen years ago. In his experience at the Good Samaritan Dispensary he felt sure that he had seen it in a number of children born in this country. This year he had treated and demonstrated a case of prurigo at the Post-Graduate Medical School which had apparently recovered.

DR. SHERWELL said that he did not recall having seen such a marked case of prurigo in so young a subject before.

DR. JACKSON said that the father of the child was said to have had the same cutaneous disease in Europe and that it had disappeared when he was thirty years of age. Most of the cases of prurigo seen in this country were of foreign parentage.

DR. HOLDER agreed with the diagnosis of prurigo and said that a case under his care at Randall's Island was nearly well during the summer, but the disease had returned after the patient had been bathing in the sea.

DR. DADE said that these cases did not seem to him to be so very rare at the clinic. He recalled one case in which the disease had been held in check by the use of sulphur ointment, cod liver oil and iron, but there were exacerbations from time to time, though they were becoming steadily less severe.

A Case of Inveterate Psoriasis.—Presented by DR. G. H. FOX.

The patient was a young woman, presented a second time with obstinate psoriasis which had resisted many methods of treatment, both internal and external. The urine had been alkalinized most thoroughly but the psoriasis persisted. Dr. Allen thought the X-ray treatment would be beneficial, the patient had been subjected to that treatment under the care of Dr. Allen. As a result of this treatment of the left hand the eruption had increased, extending up to the elbow, and presenting a severe dermatitis. A ten per cent. pyrogallol ointment had been applied to the right hand but with little benefit except a slight reduction of the thickening.

DR. SHERWELL said that only a few hours ago he had seen a case of inveterate psoriasis which had been previously treated by three members of the Society in various ways without effect. He was glad to say that the case was nearly well now under following remedies. He had given him the following tonic:

Quinine	gr. xxx.
Magnesium Sulphate	oz. j.
Sulphuric Acid Dilute	dr. iij.
Tinct. Nux Vomica	M. xxx.
Wine of Colchicum.	
Fl. Ext. Secale Cornutum aa	dr. 3iijss
Glycerine	oz. jss.
Water	oz. ij.

Misce. Sig. A dessertspoonful morning and night in a wineglassful of water, ½ tumbler of water to be taken directly after.

The following local application was also used:

Liq. Carbonis Detergens ..... dr. iij
Acidi Salicylici ..... gr. xv-xxx
Sp. to Dest. ..... m. xxx
Ungt. Aq. Rosæ ..... dr. xj

The improvement that had taken place in the past three weeks under this treatment had been very marked. He thought the antilithemic effect of colchicum was too much neglected in favor of the salicylates

The speaker had found chrysarobin very different in quality from various sources, both in action and in characteristic staining of integument.

DR. JOHNSTON suggested the use of ergotin internally and tar externally. The part, after painting, is immersed in hot water for twenty minutes. In chronic erythematous conditions this application was remarkably efficacious. The chrysarobin of the present day, it should be noted, it not nearly so powerful as formerly.

DR. FORDYCE said he had seen good effects from Unna's compound chrysarobin ointment, ichthyol, resorcin and chrysarobin, in these inveterate cases of psoriasis.

DR. I. DYER said that he had used the gelaceto-phenone a good deal, and had found that it produced much the same effect as chrysarobin without the staining and constitutional effects. He had also used thyroid extract, especially when the eruption was discrete. He scarcely ever used arsenic, believing that the staining which resulted was much more undesirable than any result that might be obtained without it. The thyroid extract and the iodide of sodium answered almost the same purpose.

DR. FOX said that some years ago he had called attention to the fact that the chrysarobin then in the market was greatly inferior to that of earlier years. He thought it would be well to go back sometimes to the Goa powder. He had tried various brands of chrysarobin on the case under discussion with no better result. He was grateful to Dr. Allen for trying the X-ray treatment, and had really hoped it would do some good. He had used ichthyol pure in this case, and also combined with chrysarobin, but neither had had any good effect, although it had proved useful in other cases.

DR. DADE said that he had had some very obstinate cases which had yielded admirably to the application of a drachm of chrysarobin to the ounce of a fifty per cent. watery solution of ichthyol. This painted on and allowed to dry, which it does readily, remains for several days. It was slower in action than the ointment, but did not stain the clothing or cause a spreading eruption. In eczema of the nose, where it is always difficult to retain an application, the chrysarobin and ichthyol would be found very useful. It caused no smarting and was very beneficial.

DR. FOX said that he had used this application in many cases, and although slow in its action he had found it efficacious and much less objectionable than the ointment. It would sometimes stain the clothing slightly, though this could be avoided by the use of a dusting powder.

DR. H. G. KLOTZ said he had used it in a few cases of so-called eczema marginatum in which he had almost abandoned the use of chrysarobin because of the irritation which it produced. He had first applied the chrysarobin in chloroform, and after this had dried had painted the part over with ichthyol.

A Case of Lupus of the Nose Treated by the Finsen Light.—Presented by DR. G. H. FOX.

The patient was a woman with lupus of the nose. She had been presented to the Society some time ago. For some years the disease had been apparently cured by tuberculin injections, but it was probably never cured on the inside of the nose, and new nodules had appeared on the outside. Twenty treatments with the Finsen light had been given at the Presbyterian Hospital, this treatment being confined to the right side of the nose, while the same number of times he had himself applied the burr to the other side of the nose. For three months there had been no treatment at all, and during this time the diseased area had become a little worse. DR. FOX said he thought all would agree that the side treated by the burr, which was the worst side, improved far more than the other side. It was only a matter of a little more treatment with the burr to make the result on that side perfect.

DR. ALLEN said he would like to see the effect of two or three months of X-ray treatment of this case, believing that the improvement would be greater than after the Finsen light treatment.

A Typical Case of Lichen Ruber (Hebra).—Presented by DR. FOX.

The patient was a woman whom he had first seen at the Skin and Cancer Hospital that day. The eruption was found in characteristic patches at the bends of the elbow, the neck and lower part of the back.

DR. DADE remarked that he preferred the name of pityriasis rubra pilaris because it seemed to him to correspond more closely with the published description of the disease.

DR. SHERWELL said that he also preferred that name because he did not think that this woman was going to die from this disease, yet this had been the termination of most of the reported cases of lichen ruber, as well as those seen by himself. He looked upon the case under discussion as a typical example of pityriasis rubra pilaris or so-called Devergie's Disease.

DR. ALLEN thought there was a good reason for keeping both names. If only one name were retained, then it must be admitted that there are certain cases which did not conform to the clinical type, and did not have the "pilaris" feature. The form presented this evening was more common than that of true lichen ruber.

DR. JOHNSTON said that he thought it was generally recognized that there is a true lichen ruber acuminatus, which does not begin on the back of the hand or present a hyperkeratosis

DR. DYER said that he had first seen this patient that day and had at once made a diagnosis of pityriasis rubra pilaris, although he had only seen one case before that. In cases of lichen ruber that he had observed the characteristics had been very different and even in the late states the papular character was maintained, whereas in the present instance there was a tendency of the lesions to break down and scale and form a patch, which sometimes became quite raw. For these reasons he thought the two terms should not be applied to the same disease.

DR. FOX asked where we were to go to get our idea of a certain disease. We all had our clinics and met with these cases from time to time, and had an opportunity to study them. It had been his fortune some years ago to see an unusual number of them, and he was positive that all of them were one and the same disease. Lichen planus had been confused by the Germans with

lichen ruber, but was recognized here as entirely distinct. He would no longer contend, however, that lichen ruber is never umbilicated. All of the cases that had been presented here in this city were certainly one and the same disease. Hebra's cases had terminated fatally, and nearly all of the cases that he had himself seen had died. He had never known one of them to recover permanently. The text-book descriptions of lichen ruber and pityriasis rubra pilaris were largely copied from foreign writers, were indistinguishable and really applied to the same disease. Hebra had described the disease so accurately that he deserved the credit of the name, and as lichen ruber was shorter he personally preferred it to pityriasis rubra pilaris, though he cared very little which name was selected so long as only one disease was admitted to exist. There were three distinct clinical forms, viz.: (1) the papular form; (2) the squamous form and (3) the rugous form. The papular and squamous forms were present in the case presented this evening. A case would at one time be entirely papular and at another time squamous. The speaker said that he had studied this disease very carefully in its clinical aspects, and felt very positive that his position, founded as it was on personal clinical observation, was correct.

A Case of Follicular Keloid of the Neck.—Presented by DR. FOX.

The patient was a young man with what some might call a dermatitis papillomatosa on the back of the neck. One patch had been burned and scraped without benefit, and the same was true about another patch upon which the electric needle had been used.

DR. ALLEN said that he was uncertain the condition now presented had begun as dermatitis papillaris capillitii, but certainly at the present time it was keloid. There was a fair chance of success he thought from X-ray treatment.

DR. G. T. JACKSON remarked that most of the keloids on the back of the neck he had seen had been in negroes.

DR. DYER looked upon these as merely hypertrophic scars, a condition very common in the South. In New Orleans one often saw in the negro keloid with absolutely no previous history of injury. It was chiefly found on the chest, arms and abdomen, and very rarely on the face. He thought the case one of dermatitis capillitii.

DR. SHERWELL said some authorities thought it doubtful if keloid was ever non-traumatic; it was more reasonable to suppose that even keloids supposed to be spontaneous in origin were the result of some slight trauma such as the prick of a pin. Even the scratching of acne pustules, or the ulcers resulting from the folliculitis as in the present case might be primary factors.

DR. ALLEN referred to a published case in which there were immense bunches of keloid starting from the lobule of the ear, the result of piercing the ear for earrings.

DR. DYER thought that many keloids were undoubtedly spontaneous, as for example, over the sternum, where the probability of injury was not great, and where the keloid was covered by true epidermis—in other words, when there was no true scar tissue. In a few of the cases he had seen, the keloids were general without any history of such extensive traumatism. He had never seen spontaneous keloid in the white.

DR. FOX said that often after syphilitic ulceration there would be a raised scar simulating keloid, but it could be removed by incision or destroyed by the electrolytic needle. The case under discussion was apparently one of secondary keloid. There were no claw-like processes or the characteristic surface, nor was

there pain, but the growth could not be destroyed permanently, and was, therefore, a true keloid. The prevalent use of the term, dermatitis papillomatosa (Kaposi) was largely due to an undue reverence for foreign names without regard for convenience or propriety.

A Case of Alopecia Areata with Atrophia Unguium.—Presented by DR. G. H. FOX.

Aged twelve years. Mother says that child was born with good head of hair but that it all fell out in infancy, and he was completely bald until he was seven years of age. Since then more or less hair has come in and fallen out from time to time, but no hair has ever grown upon occipital region. Mother also states that the boy has always had trouble with his nails since he was born, they having been brittle and deformed.

Present Condition. The usual appearances of alopecia areata are seen on head, the hair being absent from certain areas and growing luxuriantly from other regions. The most marked patches are along the border of the hair both posteriorly and on the sides. The nails of all the fingers are thin, brittle, longitudinally striated, and exfoliating in plaques specially at the anterior parts. Where these plaques are the appearance is as if a piece of the nail had been scraped away so as to leave only a very thin plate over the bed. The lunulæ of all the nails seem unaffected. There are no signs of inflammation.

DRS. JACKSON and DADE both expressed the opinion that the combination of alopecia with the disease of the finger nails was certainly a strong argument in favor of the trophic theory of the origin of the disease.

A Case for Diagnosis.—Presented by DR. CHARLES T. DADE.

The patient was a man with a peculiar condition of the nails of all the fingers. The patient said that this condition had commenced about six months ago with a dryness of the nails, and that the nails of the toes became similarly affected. The man was employed in the record room of a machine shop.

DR. H. G. KLOTZ said that with the atrophic conditions of the nails there was uniformly a turning in of the skin about the nail.

DR. JOHNSTON inclined to the neuropathetic theory of origin. The object of treatment should be to improve the circulation locally. In rare instances arsenic would act beneficially, but in the few cases in which it was indicated the arsenic must be given up to the physiological effect. The improvement of the local circulation was best effected by keeping rubber finger cots on the fingers.

DR. FOX said that the marked feature of the case was the rapid development of the atrophy. From local treatment he would expect very little except the protection of the nail. While generally opposed to the use of arsenic, experience had taught him that in trophic disturbances of the nail arsenic was the only internal remedy to be depended upon, and that the drug must be pushed to its physiological effect and must be continued for some time.

Selections.

GENITO-URINARY DISEASES.

Present Methods of Treating Ureters Severed During Abdominal Operations. —BY W. R. NICHOLSON, M.D. (*American Journal of the Medical Sciences*, April, 1902, p. 676).

Until within the last few years, any injury to the ureters demanded either a nephrectomy, or at least a ligation of the lower end of the upper fragment. Recently various methods of avoiding these measures have been proposed. These methods may be divided into three classes: First, anastomoses made with other viscera in the abdominal cavity as into the bladder and bowel; second, reunion of the several ends of the cut ureter, or uretero-ureteral anastomosis; and third, anastomosis with the external surface of the body, as upon the skin, or into the vagina and urethra.

If the whole truth were known, a percentage of deaths ascribed to shock and faulty anesthesia would be found in reality to be cases in which ureteral injury was the actual cause of death. Injury may follow ligation of the ureter, or by cutting or tearing it in the enucleation of tumors or inflammatory masses. The most usual situation of the trauma is at the bottom of the pelvis near the base of the broad ligaments.

Quite a number of operators favor the implantation into the bladder in all cases occurring below the pelvic brim, *i. e.*, where the distance from the point of injury to the bladder is not so great as to preclude the possibility of an anastomosis between them. Kelly thinks this operation should not be allowed to invade the province of uretero-uretheral anastomosis. He prefers to perform the latter operation in cases where both the severed ends of the ureter are easily accessible, when no obstruction is present between the lower end of the ureter and the bladder, and when there is no carcinomatous trouble necessitating the sacrifice of the lower portion. If, however, any of these conditions were present, he too would perform a uretero-cystotomy. Baldy, who has done this operation several times with success, claims that it may be done with success at any point of the pelvic portion of the ureter. He calls attention to the apparent increase in the length of the ureter, which results from its dissection from beneath the peritoneum by which its markedly curved course is converted into a straight line. Kelly has recently called attention to a ureteral guide which he introduces into the bladder through a small incision in the wall, and then passes out through the usual bladder incision. Upon the bar of this instrument is threaded the upper fragment of the ureter, and then it is easily drawn into the bladder and the usual stitches applied. This procedure presents the objection that it makes necessary an extra incision in the bladder wall, which seems an unnecessary traumatism, since the free-hand method of operation (Van Hook's) has not presented any marked difficulty. Emmet claims that the chance of bladder infection in bladder anastomosis is greater than in the case of uretero-ureteral anastomosis, because in the former operation the normal orifice of the ureter is not preserved. The real safeguard, however, is not the so-called ureteral valve, which is probably non-existent, but the presence of an uninjured vesical mucous membrane. As further evidence it may be mentioned that in experiments in which the ureters were implanted in the bowel, it was found that the mere im-

plantation of the ureteral orifices alone did not prevent infection, while if a portion of surrounding mucous membrane were transplanted uninjured with the ureteral orifice, the chance of infection was greatly reduced. Bovée believes that one of the possible dangers of the bladder implantation is that either a constriction of the ureter will be caused, with its resulting evils of hydronephrosis, or that a too free opening, with the absence of the valve, may permit a backward flow of urine, with the same result. These complications, however theoretically possible, have not been observed in practice by Nicholson. The backward flow of urine in any case of bladder implantation, which is certainly even theoretically only problematical, will in practice be prevented by the high point in the bladder-wall at which the anastomosis is made, and by the use of the catheter at suitable intervals after the operation.

The method of end-to-end joining of the severed ureter, has also received much attention of late. The inherent difficulty of this operation is one of its greatest drawbacks. The flaccidity of the walls and minuteness of structure of the ureter, as well as the depth at which most of these injuries occur, which necessitates that the repair be carried out in the bottom of the pelvis, have caused operators to favor bladder implantation. Kelly does not feel that these two operations are in any sense rivals, but thinks that there are indications for the employment of each.

Different methods of joining the severed ends of the ureters have been proposed, as follows:

1. Lateral implantation, or the end-in-side method. Originated by Van Hook. (Free hand method.)

2. Transverse end-to-end approximation.

3. Oblique end-to-end approximation. Bovée's method.

4. End-in-end. Done by various experimenters, and once in a human case, the result in the latter being a success.

In the main the dangers of these methods of anastomosis may be said to be urinary leakage, fistulæ, and constriction. Especially are these dangers threatening in the end-to-end method, *i. e.*, without invagination, and in the end-in-end method, with invagination. Van Hook's method seems to be free from these objections to a great extent, on the authority of his own experiments on animals. Kelly was the first to use this method (1893) on a human patient. In 1897 Bovée collected 12 cases of anastomosis of the divided ends of the ureter, of which seven were done in Europe and five in America. All the American cases lived, and three of the European cases died, though in none of them could the death be ascribed to the ureteral complication. In the series there was only one which showed a leakage, and this soon ceased. Three were done by Van Hook's method. Seven were end-to-end approximations, and although three died, there was no leakage in any of the seven, and the deaths, as far as could be ascertained, were not due to the ureteral conditions.

The possibility of intestinal anastomosis has presented itself to investigators since 1851, when it was performed in a case of exstrophy of the bladder by Simon. This patient died in a year with marked kidney changes. Intestinal anastomosis, if feasible, would be much easier of accomplishment than uretero-ureteral anastomosis, because of the size of the intestine, and also because there would be a complete avoidance of dangerous traction, which has been one

of the causes of the many failures of the latter method of operation. The ascending infection which involves the vast majority of all ureters thus anastomosed, is the one factor which is unsurmountable. Aside from this difficulty there is little reason why the intestines should not thus be utilized, since it has been found that the large bowel in the dog can assume the functions of a urinary reservoir, and that sphincteric control will be maintained. The opinion is expressed by some that notwithstanding the general belief to the contrary, the mere presence of urine in the bowel produces nothing more than a rather increased frequency of evacuation.

In the main, the difficulty in uretero-ureteral anastomosis is one of infection of the ureters and kidneys, and to a less extent, the causation of a certain amount of constriction, leading to kidney contraction. Simple anastomosis of the ureters to the intestines is not a permissible operation, as if any immediately fatal result is avoided, there will be certainly a gradual kidney involvement, sooner or later manifest. The operation proposed by Maydl, and elaborated experimentally by Peterson, may in the future give better results, but at present their results are not sufficiently encouraging to render its adoption justifiable in the human patient.

With regard to the remaining sites of ureteral implantation, but little need be said, as from a practical point of view, none is of any appreciable value. Kelly considers skin implantation in the same class with nephrectomy. The vagina as a site for implantation has also nothing to commend it. A. L. W.

Suprapubic Cystoscopy.—By DONALD KENNEDY, M.D. (*Medical Record*, April 10, 1902, p. 610).

While performing suprapubic puncture of the bladder to relieve prostatic retention, the writer conceived the idea of examining the interior of the bladder through the opening made by the trocar-canula for the puncture. He had a trocar made to fit a No. 21 Otis endoscope, which he calls "trocar endoscope," and employed it in the case of a man in which it was found impossible to insert a Mercier coudé or bicoudé. The bladder was tapped with the instrument and nine ounces of urine withdrawn. This was repeated every two hours until the bladder was empty. The few drams of urine remaining were "sucked up" by means of a bulb attached to a catheter. The bladder being empty, the lamp was attached to the tube. The general condition of the bladder was plainly visible; areas of inflammation were made out; the mouths of the ureters detected, and had stone been present in the prostatic pouch, it would have been revealed. Of the size and contour of the prostatic lobes much could not be determined, owing to the fact that with reflected light the distal end of the tube had to be almost in contact with the bladder wall in order to illuminate it, thus giving a very limited area under observation.

This case is reported as a preliminary report of further studies being made in this direction. A. L. W.

Clinical Study of a new Silver Salt in the Treatment of Gonorrhea.—H. M. CHRISTIAN, M. D. (*Med. Rec.*, Sept. 27, 1902, p. 494).

Christian gives the results of an extended study of the treatment of gonorrhea with the new silver preparation, silver vitellin, or argyrol, its fanciful name.

His investigations were made with reference to the following points:

1. Effect of the remedy upon the discharge from the urethra.

2. Time at which the gonococci disappeared after treatment was first employed.

3. Whether the injection caused any pain in the urethra, or gave rise to any signs of urethral irritation.

4. Number of cases presenting any complications.

5. Length of time required to cure.

His conclusions are summed up as follows:

"The results obtained in our cases at the University Hospital have convinced me that we have in silver vitellin the best silver compound ever offered to the profession for the treatment of gonorrhea, for the following reasons:

1. That it is absolutely free from any irritating properties, solutions as high as 5 per cent. causing no discomfort.

2. That the gonococci on and beneath the urethral mucous membrane are rapidly destroyed.

3. The amount of urethral discharge is in a majority of cases at once lessened in a marked degree.

4. The actual duration of the disease is shorter than is obtained by the use of any other silver salt. In our cases thirty-eight were cured in from two to four weeks."

The Use of Argyrol in the Treatment of Acute Gonorrhea.—G. K. SWINBURNE, M.D. (*Med. Rec.*, 1902, Oct. 11, p. 574).

In this article the author seeks to outline in general what he considers the best method of using this new and valuable addition to the therapeutics of this disease.

He uses several methods according to circumstances, such as the severity of the disease, the chance of aborting the disease and the patient's ability to come frequently or not.

Treatment may be daily. In such cases he irrigates the urethra with one quart of hot 1-1000, or 1-2000 solution of argyrol and follows this by the injection of a 2 or 5 per cent. injection or instillation as the case demands, and gives the patient a 2 per cent. solution to use at home once or twice a day by injection in addition to the office treatment.

Patients who can only get to the office once or twice a week, receive the same treatment at the office and use 2 per cent. or 5 per cent. two or three times daily at home.

He uses irrigation with argyrol before the use of urethral instruments, where formerly he used permanganate solutions.

In chronic cases he claims good results with the use of this drug. And he uses as a lubricant or sounds in some cases a 5 per cent. ointment made with adeps lanae as a base, the argyrol being rubbed up with just enough water to render it smooth before incorporating it in the ointment.

He lays great stress on the non-irritating qualities of argyrol; 10 per cent. dropped in the eye produces no pain; 20 per cent. even in the urethra has produced no painful reaction even in acute cases.

He sums up as follows, that the drug has decided gonococcidal powers; it has a decided effect in reducing and allaying inflammation; it can be used safely in almost any strength and at any stage of the disease; the injections can be repeated almost as frequently as desired. He has seen no unpleasant symptoms due to the use of the drug and believes it to be a very valuable addition to our means of fighting the disease.

CUTANEOUS DISEASES.

1. **A Case of Nævus Vasculosus Mollusciformis.**—PROF. SIEFERT (*Archiv f. Derm. u. Syph.*, Vol. 59. p. 197).

2. **A Rare Case of Nævus Spilus.**—T. FABRY (*Arch. f. Derm. U. Syph.*, Vol. 59, p. 217).

3. **A Contribution to the Knowledge of Soft Pigmentary Nævi.**—JOHANNES FICK (Prof. Ehrmann's Laboratory, Vienna), (*Arch. f. Derm. u. Syph.*, Vol. 59, p. 323, 1902).

1. Siefert's patient was fifty-three years old. He was born with a fiery red mark on his face, which remained flat and smooth in the beginning, but later increased in thickness and in the last few years was covered with elevated tumors. Of special interest here, are the mucous membrane of the upper gums and mouth. It was thickened, hypertrophied and of soft consistency. The color of the affected mucous membrane was of bluish-red tint. No histological examination was made.

2. Fabry's case deserves attention from the fact that the nævus occupied all parts of the body, except face and scalp, and even there the pigmentation was marked. The pigment-nodes were quite smooth. No signs of any elevation could be noticed. There was an entire absence of any sign of hypertrichosis or telangiectasia. From his microscopical examination he is inclined to draw the conclusion that the pigment is derived from the blood from the smallest end arteries.

The contribution of Fick deserves great attention. After giving a detailed description and pictorial presentation of his microscopical findings from eight sections obtained from living patients, he enters into a spirited and well delivered discussion upon the origin of the pigment in the nævi. He goes over the whole unsettled and debatable question by presenting the views of other writers and then criticising them in the light of his own observations. He arrives at the following conclusions: The pathological increase of the pigment in the nævus is not the cause of the formation of the tumor. The formation and growth of nævus cells on one hand, the increase of pigment on the other hand, are two coordinate parallel occurrences, but not combined pathological incidents. 2. The nævus cells contain pigment only when they are in proximity to melanoblasts, with which they were in many places seen in contact.

3. In some nævi giant cells are found, while other signs of excessive hypertrophy or inflammation are absent. These giant cells differ from the nævus cells not only by their size, but also by their capacity for having their nuclei stained more deeply and by the presence of a basophile substance in their protoplasm.

4. The melanoblasts branch out in prolongations between the epidermic cells and merge into them. They are localized partly between the epithelial cells, partly on the border of epidermis and corium, partly between the nævus cells, and partly in the deeper layers of cutis around the vessels.

5. Regarding pigmentation, the nævus cells behave in the same manner as the epithelial cells.

6. The pigment which can be demonstrated in nævi is localized in the various cells, epithelial, nævus, giant cells and melanoblasts.

7. The histological pictures of pigmentary soft nævi prove the correctness of Ehrmann's view of pigment formation.

1. **Linear Skin Eruptions upon the Lower Extremities.**—Drs. L. Fischel and F. Pinkus (*Derm. Zeitsch.*, Vol. IX., p. 123, 1902).

2. **A Contribution to the Knowledge of Linear Diseases.**—T. Bertamini (Prof. Jarisch's Clinic) (*Arch. f. Derm. u. Syph.*, Vol. 62, p. 35, 1902).

Since Blaschko's publication "The distribution of the nerves in the skin" cases have been reported which serve either to affirm or to deny the distribution of certain skin eruptions along their course. The writers report three cases: Lichen ruber verrucosus, lichen chronicus linearis (Touton) and a supposed lichen planus upon the lower extremities. They do not consider the distribution of the efflorescences in any way connected either with the course of the nerves, or with the distribution of blood vessels, or with the arrangement of the hair. Although mindful of the irregularities of the distribution of the nerves of the lower extremities, no certain rule can be laid down as to the course of linear nævi.

2. Bertamini in reporting his case of a woman, forty-six years old, suffering from a linear eruption of one year's standing on the abdomen, lumbar region and lower extremities, describes the histological characteristics of the eruption and in a critical review of the classification of the affection concludes that it is to be considered rather a linear dermatitis, lichen ruber planus, than a nævus.

1. **The Effect of Roentgen Rays upon the Normal and Diseased Skin.**—W. Scholtz (Dermat. Clinic, Univ. of Breslau) (*Arch. f. Derm. u. Syph.*, Vol. 59, 1902, pp. 87, 241, 421).

2. **Exact Measures in Radiotherapy.**—Béclère (*Jour. d. mal. cutan. et Syph.*, Vol. 14, 1902, p. 172).

3. **The Influence of Roentgen Rays upon the Different Varieties of Sarcoma,**—William B. Coley (*Medical News*, 1902, p. 542).

4. **A Case of Epithelioma Complicating Lupus Erythematosus, Treated by Scaping and Healed by the X-Rays.**—G. G. Stopford Taylor (*British Medical Journal*, 1902, p. 1080).

To determine the action of X-rays upon the skin, Scholtz brings forward his experimental and histological researches and clinical observations. In his experimental researches he tries to determine what is the active agent of the rays and what action is this agent capable of producing. He conducted his experiments mostly on young pigs, the skin of which in every particular is very much like human skin. The active factor is the rays themselves and not the electric waves; the action is produced not only at the point of entrance but also at the point of exit of the rays. The skin alone responds to the action, inner organs and tissues seem not to be influenced. The clinical effect of the rays is visible only several days after the application. The rays have no bactericidal power, and therapeutically this hardly plays any part. Histologically they chiefly and primarily influence the cellular elements of normal skin; they undergo a slow process of degeneration, while the collagenous and elastic tissues, the muscular and cartilagenous elements are not at all or only in a slight degree altered. Those tissues suffer only secondarily—owing to the degeneration of the cells and the inflammatory reaction.

2. The epithelial cells are the first which undergo degeneration, the cells of glandular organs, of vessels, muscles and connective tissue are changed in a lesser degree.

3. The degenerative process takes place in the nucleus as well as the protoplasm.

4. As soon as the degenerative process of the cellular elements reached a certain point, symptoms of reaction come into view, such as engorgement of vessels, serous exudation into the tissues, appearance of leucocytes and white blood corpuscles. When the application of the X-rays causes a severe process, the leucocytes penetrate en masse the degenerated cells and bring about their complete destruction.

5. The changes which occur in the smaller and larger vessels probably play an important rôle in the process of healing following X-rays.

After determining the histological changes in normal skin, the writer examined histological sections from skin affected with lupus. Here the reactive inflammation and hyperæmia, which take place, and are concentrated in the affected tubercle itself, are the healing agents and the bactericidal action of the X-rays can hardly be considered. The same reaction he found in lepra, one case, carcinoma of the skin, four cases, mycosis fungoides, one case, psoriasis, five cases.

When the writer had made clear to himself the action of the X-rays he then undertook clinical observations on a large scale. During the last three years two hundred and twenty (220) cases of various skin diseases have been so treated. From sixty-four (64) cases of lupus he draws the conclusion that in severe cases on energetic treatment with the X-rays, brings about a relative by satisfactory result in a few months—giving better cosmetic results than curretage. In the milder more superficial cases of lupus energetic, intermittent application is most satisfactory; no scars. Lupus erythematosus, five cases good cosmetic results. The effect of X-rays upon diseases of the hairy scalp and beard can hardly be regarded as satisfactory. The rays did not destroy the parasite of favus or tinea tonsurans. They removed the hair, but the disease returned with the growth of the new hair. In sycosis and folliculitis barbæ only in mild cases was a definite case obtained, not in severe long-standing attacks.

In acne vulgaris and acne rosacea there was no effect. New efflorescences of acne appeared during treatment. In eczema the results were satisfactory, less moisture, less scaling, and the objective symptoms improved in a remarkable manner. Good results were obtained in psoriasis, nearly entire disappearance in some patients and in others an "absolute" disappearance of the eruption. Since in some cases new psoriatic lesions appeared during treatment, the writer expects relapse, but he thinks that "an intermittent X-ray treatment" during several years may lead to a permanent cure. In pruritus vulvæ an improvement was noticed. No results obtained in lepra. In carcinoma of the nose after producing a necrotic action, a microscopical examination of the tissues did not demonstrate any carcinomatous tissue. A final opinion in such cases can only be expressed after years of observation.

The capital factor in the method of application of X-rays is the quality of the rays used. There exists a whole scale of X-rays which differ from each other by their power of penetration, on which depend their effects produced upon living tissues. Rays which penetrate very little, being quite entirely absorbed successively encountered layers, have a deleterious action upon the skin, which may end even in its complete destruction.

Rays which penetrate deeply, being scarcely at all absorbed by the tissues

they traverse, exercise no action or only a slight one upon them: they are indifferent. Then there exists between those two extremes, a category of rays which have only mild penetrating power, which, being partly absorbed, in certain pathological conditions, can provoke in the thickness of the skin a reaction, leading to a curative effect.

It is then important for the physician to be able to produce at his will, rays more or less penetrating, and especially to be able to determine the exact degree of penetration of the rays he is using. Béclère (2) describes three instruments of French invention which permit the physician to satisfy himself on the two foregoing points. The instruments are Villard's ampoule, the spintermeter, and the radiochrometer of Benoist. He gives a detailed account of their construction. Coley (3) gives an account of the influence of the rays upon fourteen cases of different kinds of sarcomata: eleven (11) round celled, two (2) spindle celled, and one of a recurrent osteosarcoma (no micros. exam.) The following regions were occupied: Neck, the parotid, femur, superior maxilla, muscles of the thigh, mastoid portion of temporal bone, pectoral axillary regions, and back (fascia). He draws the following conclusions: That (1) the X-ray has an inhibitory action upon the growth of all forms of malignant diseases and especially upon sarcoma, producing (2) even in inoperable cases a total disappearance of the tumor; their action is advantageous not only in sarcoma but in every variety of cancer, not only upon the skin but probably in tumors located deeply; (6) the X ray has a very marked influence upon the pain of nearly all types of malignant tumors, causing entire relief in the majority of cases.

Very good results have been obtained by Taylor (4) by combining the application of X-rays with preliminary scraping in a man of 59 years who suffered with an epithelioma (microscop. diagnosis) and lupus erythematos of the nose. The epitheliomatous ulcers originated from a horny excrescence on the tip of the nose. As much as possible of the growth was removed with a scraper and the surface submitted to the influence of the rays. Ten minute exposures were given daily for a month, a rest for ten days and again an exposure for five minutes for a week with alternate periods of rest. Four months after beginning of the treatment the nose was completely healed.

Therapeutic Reports

NOTES ON CHALYBEATE THERAPY.

By Dr. J. W. Frieser,
Vienna, Austria.

The field of indications for the medicinal use of iron is quite extensive, for, aside from anemia and chlorosis, it is called for in all diseases in which anemic conditions occur either during their course or as their sequel—in short, in all cases in which, through some pathological state or another, the integrity of the blood is affected and impaired in a greater or less degree. To this group belong, first, the large number of constitutional affections, especially scrofula and rachitis; second, tuberculosis in certain stages of its development; third, certain nervous disorders which are commonly attended with anemia, such as neurasthenia and hysteria; fourth, all conditions of weakness and exhaustion following severe acute febrile diseases or appearing during the period of convalescence from other serious diseases; and, finally, the anemias arising in the course of chronic and wasting disease.

The chalybeates comprise a quite considerable number, all of which are intended to fulfil the therapeutic aim of supplying the lack of iron which is the source of the anemic condition, of bringing about an improvement of the pathological state of the blood, and of promoting blood formation in a normal manner. Although at the present time we are still imperfectly informed as to the primary causes of anemia and chlorosis, and do not as yet possess a clear insight into the inner workings of the pathological process, it must, nevertheless, be considered as demonstrated that the deficiency of iron in the body has its origin in certain functional anomalies of the blood-forming or blood-conserving organs, and that it is the result either of pathological degeneration or of a lessened production by them. Conformably to the causal indication, the aim of treatment in these diseases is, therefore, to replace the deficiency of iron, which plays so important a part in the human economy, as completely as possible, and this can only be brought about by the introduction of sufficient quantities of ferruginous medicaments in an absorbable form.

According to recent and thorough studies of this subject we have to deal in anemia and chlorosis, as well as in other anemic forms of disease, besides the loss of iron, with a marked diminution of the manganese, which, like iron, is not an unimportant constituent of the blood, and for this reason an adequate equivalent appears necessary.

The number of ferruginous preparations at our disposal is much larger than in the case of any other medicaments, and almost daily we have an opportunity of acquainting ourselves with new remedies of this kind, so that, in view of the actual overflooding of the pharmaceutical market at the present time, it is not easy to find our way and to always make the proper choice. A glance at the large series of preparations which during recent times have been either newly discovered or introduced in an improved or altered form, gives us an approximate idea of the new paths and aims followed in modern medication. Our widened knowledge of the physiological action of remedies, and the constant striving of chemists to produce drugs of the greatest possible specific nature, have enriched the materia medica with very valuable acquisitions which permit of a method of use corresponding to the requirements and more convenient for the patient.

It can be easily understood that the medical profession gives its full attention to any improvements in this domain, and especially in regard to the important criterion that the preparation under consideration must be of such character that it is easily absorbed, and hence can be utilized by the organism.

We are led more and more to recognize the fact (and this subject I have discussed in detail in a former contribu-

tion) that inorganic iron, owing to its slight absorbability and assimilability, as well as its difficult digestibility and its irritating action upon the mucous membrane of the digestive tract, is not at all adapted for the rational treatment of the forms of disease considered here, and that only iron of organic character which approximates in its composition to the iron present in our foods presents those advantages in improving the quality of the blood which conform most closely to the demands of a logical and successful therapy. In this connection I must refer to the view of Bunge, which nowadays is shared by nearly all clinicians and pharmacologists, that iron introduced in the inorganic form is either not at all absorbed by the intact mucous membrane of the gastro intestinal tract, or only in minimum and therefore in inadequate amounts, and hence cannot be utilized for the formation of blood. Owing to this theory, which is forcing its way more and more to the front and is being accepted by many of the most vigorous adherents of the old iron therapy, the efforts of chemists have been more and more directed toward replacing the inorganic preparations of iron by easily assimilable and absorbable combinations, and from these have resulted iron albuminates and iron peptonates, which, on account of their superior properties, have steadily gained in popularity. That, in spite of the existing medication and the demonstrated favorable influence of iron in the above-mentioned diseases, the results of ferruginous medication are occasionally uncertain and imperfect is, in my opinion, due to the frequently incorrect choice of the preparation employed and to the routine method of administration.

Hence, in judging a ferruginous preparation, we must decide the important question as to what should be the requirements of a useful and efficient combinate in every direction if all demands are to be met in a scientific and practical manner. Above all, such a preparation must be capable of a high degree of absorption and assimilation, must be digestible, easily borne, palatable, and must not in any manner exert disturbing by effects upon the functions of the organism.

According to my extensive observations, these postulates are fulfilled in a satisfactory manner by Pepto-Mangan (Gude). I have had frequent opportunities, in a considerable number of cases (42) in which the preparation was employed with success, to acquaint myself with its therapeutic value and its beneficial medicinal properties.

In the administration of Pepto-Mangan to anemic and chlorotic patients I have been able to make the positive observation that under its use the constitution of the blood underwent a very satisfactory and sometimes remarkable improvement, often after a comparatively short period of treatment. The examination of the blood frequently showed a rapid increase of the number of red blood cells and of the percentage of hemoglobin, this being attended by a marked improvement of the general health and an increase of strength. Its advantageous chemical composition and its excellent medicinal properties, such as easy assimilability, high absorption and assimilation power, and the absence of any deleterious or disturbing by-effect, illustrate particularly the advantages of this remedy, whose efficiency is evident in most cases.

A glance at the physical character and composition of the preparation will easily enable us to form a correct idea of its value.

Pepto-Mangan contains iron and manganese combined with peptone in the proper proportions and in a readily digestible and absorbable form, so that the preparation can be completely utilized by the organism. As is well known, the peptones represent artificial predigested products which when taken into the organism make no special demands upon the digestive functions, which in anemic and chlorotic persons are usually weakened and impaired in action. This fact is the more important, since in these cases the digestive process and the secretion of gastric juice is usually reduced, in consequence of which the nutrition is quite impaired, while frequently there is a condition of hyperacidity of the gastric juice. It has been most gratifying to me to observe that during the use of Pepto-Mangan, which experience has taught me is particularly adapted in these maladies, it does not interfere with or exert any disturbing effect upon the digestion. On the contrary, under its administration the appetite and the digestion are stimulated in a very satisfactory manner.

As a rule, during treatment with Pepto-Mangan the improvement in the constitution of the blood, as shown by physical examination, was accompanied by a beneficial effect upon the general condition and strength. The appearance and aspect of the patients improved visibly, the digestion and nutrition progressed favorably, and the patient felt better, happier, and more vigorous. Disturbances of the gastro intestinal tract, such as pressure or pain over the stom

ach, nausea, a disagreeable feeling of fulness, a diminution of appetite constipation, congestions, etc., which are so frequent during the administration of other iron preparations, especially those of inorganic character, were scarcely ever observed during the use of Pepto-Mangan (Gude). On the contrary, in those cases in which there is a tendency to constipation and a marked atony of the gastric functions my experience has led me to regard this remedy as especially useful and effective. Under its administration the functions of the intestines, especially the peristalsis, are often stimulated in a remarkable manner, and the existing constipation yields to a regular condition of the bowels.

It seems to me particularly noteworthy that often, even after a brief use of Pepto-Mangan, the anemic appearances, especially the often marked apathy, lassitude, and drowsiness, the palpitations of the heart, and headache, disappeared in a very satisfactory manner, and that even in those patients who suffered from insomnia frequently a good refreshing sleep occurred. Even in those instances in which a variety of other ferruginous preparations had proved unavailable the prolonged use of Gude's Pepto-Mangan often gave very gratifying results, so that occasionally a manifest and positive cure occurred after four to six weeks' treatment.

Aside from primary anemia and chlorosis, the preparation produced beneficial effects in all those diseases which are apt to be attended with or followed by anemic conditions of various kinds and degrees. As a rule, its action in scrofula and rachitis was excellent, and no less favorable in the incipient stages of tuberculosis in which anemic phenomena are frequently observed. Furthermore, it proved of value in conditions of debility, during convalescence from acute febrile and exhausting diseases (pneumonia, typhoid, and other infectious diseases), and finally in those chronic wasting maladies often accompanied by anemic states, such as tuberculosis, malaria, protracted gastro-intestinal catarrhs, and chronic dyspepsias, in all of which the administration of a strengthening and tonic remedy appears indicated.

An especially advantageous influence is exhibited by Pepto-Mangan in the case of weakly, anemic, and ill-nourished children, as well as in anemic women. In these cases its use often proves most serviceable, so that I have learned to award it the preference and prescribe it usually with excellent results.

Particularly striking was the success of treatment with Pepto-Mangan in three cases of very severe chlorosis and in two cases of marked acute anemia following considerable losses of blood. In a comparatively short period of administration (five weeks) a most remarkable improvement, both of the general state and the appearance of the patient, as well as of the condition of the blood (rapid increase of the number of red blood cells and percentage of hemoglobin), took place. I cannot refrain from mentioning that in several cases in which the administration of iron appeared contraindicated owing to marked digestive disturbances or to an acute febrile state, Pepto-Mangan was prescribed by me without any drawbacks, but rather with eminently satisfactory results.

According to all these observations in my practice, which are completely confirmed by many favorable reports from other sources, I would regard Pepto-Mangan (Gude) as an excellent and effective remedy, which is entitled to a prominent place among the iron preparations at present at our disposal.

While characterized by a high degree of absorbability and assimilability, being easily digested and well borne, this remedy is free from any deleterious properties, is willingly taken by the most capricious patients, and is uniformly well tolerated. The fluid form and pleasant taste of the preparation render its administration convenient and agreeable for the patient, and, as must be particularly emphasized, the remedy, even when administered for months, does not excite the least aversion, an advantage which certainly is not to be underestimated. A review of those cases which were particularly benefitted by Pepto-Mangan would be best calculated to demonstrate its high therapeutic value, but must be omitted here in order that the present article might not become too voluminous.

In view of the recognized advantages of the preparation and the favorable results obtained with it, it should be esteemed as a very valuable acquisition to the materia medica, and can be warmly recommended for extensive use in the treatment of anemic conditions and chlorosis.

It is my custom to direct that Pepto-Mangan be taken in these cases to the exclusion of other treatment, and only in combination with appropriate dietetic measures, for periods of several weeks, and if necessary longer, three to four months. For adults I prescribe three tablespoonfuls to three to four dessertspoonfuls daily, for children three teaspoonfuls daily, in water or some white wine. During the entire time of administration I prohibit the use of raw fruit,

acid or highly-spiced dishes and order a vigorous and regulated diet. In severe cases of anemia and chlorosis I recommend rest in bed for some time, and if possible have the patient placed in a well-ventilated sitting-room; while in the lighter cases I order, besides the medicinal treatment, a frequent sojourn in the open-air, and if possible a prolonged stay in the country in a carefully selected place, and short and non-fatiguing walks.

In some instances I have observed excellent results from a rest cure in conjunction with ferruginous medication and appropriate hygienic and dietetic treatment.

CASES IN HEMATHERAPY FROM SOUND VIEW HOSPITAL.

By T. J. Biggs, M.D.,
Stamford, Conn.

CASE I. SKIN-GRAFTING WITH CALLUS SHAVINGS, IN BLOOD.

Mary M.; age 60 years; Irish. Diagnosis, Ulcer of Leg. Patient admitted to Hospital March 3, 1902. She had a large varicose ulcer situated over the tibia, about 3½ by 2 inches. This condition had existed for nine years, and during that time in spite of all treatment employed had never entirely healed. It had been skin-grafted in the old way, three times unsuccessfully. At the time of entering the hospital the patient suffered so severely from pain that at times she would cry out. She was put to bed, secretions regulated, the ulcer cleaned up by means of a dermal curette, and dressed for the first twenty four hours with a Thiersch pack. On the morning of March 5th, after the surface had been thoroughly cleaned up, a bovinine-pure pack was applied and kept wet with the bovinine for twenty-four hours.

On the morning of the 7th, I determined to employ grafts secured from a callus on the small toe, in order to demonstrate the technique of this mode of skin grafting to five visiting physicians. The mode of procedure was as follows: The callus was thoroughly scrubbed up, and the external layers scraped off. Then thin sections of the layers next to the true skin were obtained by means of a very keen razor. Nine of these were deposited on the ulcerous surface. Over these were laid strips of perforated rubber tissue, then strips of plain bi-sterilized gauze saturated in bovinine, and a bandage applied. The nurse was instructed to keep the dressings wet with bovinine pure. This dressing was removed on the 14th, and it was found, much to the delight and astonishment of the visiting physicians, that out of the nine grafts employed eight were firmly adherent and in a healthy growing condition. The ninth had become displaced and was removed. The wound was now dressed with bovinine pure; the dressings being kept wet, and changed once in twenty-four hours. Co-incident with the local dressings, from the outset, the patient had been given a wineglassful of bovinine in milk alternating with wine and beer every three hours. On March 24th she was discharged cured, the entire surface having become covered with new healthy skin.

This experiment has been employed frequently enough by me to demonstrate that where the technique is carefully followed it will in the maiority of cases yield the most gratifying results. A point of interest in this case and a usual one, is that from the day of the first dressing of the bovinine up to the time the patient was discharged, she was relieved of all pain.

CASE II. SKIN-GRAFTING WITH SKIN-SCRAPINGS, IN BLOOD.

Anna H.; age 12 years; American. Diagnosis, burn of right hand. Patient was admitted to hospital March 8th, 1902. As a result of the burn she had on the back of her hand an ulcerous surface 2 by 1¾ inches, very painful, and in spite of three months' treatment had refused to heal. It was impossible in this case to secure skin-grafts, and as I wished to demonstrate to the visiting physicians who were present the efficacy of *skin-scrapings* as a means of bringing about a rapid healing of small surfaces where grafts could not be obtained, with an ordinary vaccinating comb I secured skin scrapings from the little patient's arms, legs and back. These were deposited within the periphery and dressed as in the other case. The dressing was kept wet with bovinine pure until the morning of the 16th, at which time it was removed and to the delight of the visiting physicians as before, the surface was found to be almost entirely healed, there remaining unhealed only a small space about the size of a ten cent piece, in the center. The wound was now dressed with bovinine pure and the nurse ordered to change it every 24 hours. Internally the patient had been getting a teaspoonful of bovinine every two hours in peptonized milk. March 24th she was discharged cured.

HEROIN HYDROCHLORIDE AS AN ANAPHRODISIAC.

By Dr. Arthur Strauss,
Bremen.

No references as to the anaphrodisiac action of heroin hydrochloride has thus far occurred in the literature, most of the reports on this remedy relating particularly to its influence upon the respiratory organs. In the following I desire to present the results of my experiments with heroin hydrochloride in conditions of sexual excitement and in cases of increased and painful erections which so frequently accompany an acute inflammation of the urinary organs. At first I employed heroin in a series of ten cases of pollutions. Most of the patients were young persons who consulted me complaining that they had from two to four nocturnal pollutions every week, and in consequence had a feeling of great weakness on the following days. Frequently they suffered with pains in the back and a more or less marked feeling of heaviness in the head. In all these cases the pollutions rapidly diminished under the influence of heroin. In one instance, that of a young man, 21 years old, who was troubled with pollutions almost every night, none appeared during the following week after taking ⅙ grain of heroin every night. During the following week they occurred only rarely, and his condition perceptibly improved. In general, I ordered during the first week one powder every evening, and then, according to the frequency of the pollutions, increased the intervals between the administration of the drug to every second and third night. Of course, I also gave general directions, such as sleeping upon a hard mattress and upon the side, the avoidance of too heavy meals at night, alcoholic drinks, and cold or lukewarm ablutions followed by friction. Under this treatment I observed that heroin has the same beneficial effect as bromide of potassium with camphor and lupulin, without, however, feeling convinced that it had any special advantage over the latter.

The second group of cases related to those forms of sexual neurasthenia in which, in consequence of sexual excesses, the affection had gone on to physical impotence, to seminal emissions, and those nervous disorders which are commonly the result of onanism, as weakness, lack of confidence, headache, lassitude, defective memory, etc. In four of these cases heroin acted less promptly than in those of frequent pollutions; in one instance it failed completely, the spermatorrhea persisting in spite of the introduction of a suppository containing ⅙ grain of heroin at night and the installation of nitrate of silver. On the other hand, when applied in the same form in another case it had a rapid and permanent effect. There was present in this case a spermatorrhea due to excessive masturbation, which was so marked that even during coughing and jumping a discharge of semen occurred. After the use of three suppositories of $^1/_{16}$ grain each, introduced at night, considerable improvement manifested itself, and the young man was entirely cured in the course of a few weeks. In two other cases heroin alone failed to remove the spermatorrhea, but when conjoined with local treatment and general dietetic and hygienic regulations a cure resulted.

The third group of diseases of the urinary tract related to those numerous cases of gonorrhea, especially the acute and subacute form, with their complications, epididymitis and prostatitis, and diseases of the posterior urethra and bladder. In about 20 cases of the most varied character I administered heroin for the relief of the erections, pains in the scrotum or in the urethra during acute inflammation as well as catarrh of the bladder; and further, in disorders accompanying inflammation of the prostate.

Want of space prevents me from reporting each one of these cases in detail. In almost every instance I observed good results. The pains diminished; the erections disappeared; the patients became more quiet, and the inflammatory phenomena appeared to be favorably influence. It goes without saying that general and local measures formed the main treatment, but there can be no doubt that heroin is an important adjunct, and can be highly recommended in doses of ⅙ grain, internally or in the form of suppositories.

Finally, I tested heroin after operations in which erections and pains are common sequelæ, especially in operative procedures for phimosis, which are often followed by painful erections and sleeplessness. Here heroin acts as a sedative and hypnotic, and on several occasions I found that when it was not administered the patients were restless at night. A dose of ⅙ grain procured a refreshing sleep, and several times it has acted better than sulfonal or bromide of potassium.

According to these experiments heroin is an excellent remedy for all urinary conditions in which it is desirable to produce an anaphrodisiac effect or to relieve inflammatory or painful manifestations. It is always well tolerated, and no

unpleasant by effects were ever observed. It had no untavorable influence upon the digestive tract, and was devoid of the constipating tendency of morphine. Owing to its freedom from the unpleasant concomitant effects of the latter remedy it constitutes an excellent anaphrodisiac after operative procedures and in inflammatory conditions of the urinary tract as well as a sedative and analgesic. —*Muenchener Med. Woch.*, Sept. 9, 1902.

THE X-RAY AND TRIKRESOL IN ALOPECIA AREATA

By M. L. Heidingsfeld Ph.B., M.D., Cincinnati.

Professor of Dermatology, Laura Memorial Medical College; Clinical Lecturer, Miami Medical College; Dermatologist, Presbyterian Hospital.

Some of the cases which have come under my notice during the past few years have proven to be so obstinate and refractory to the various forms of older medication, and so prone to recurrences, that I felt obliged to seek newer fields and to try some of the more recent remedies. Of the older remedies, chrysophanic acid in traumaticin has served me best, and though objectionable in a measure, because it produces marked discoloration and frequently troublesome matting of the hair, its use has been followed in the majority of cases by prompt and marked improvement, and in not a few of the cases by a radical and permanent cure. Failure to check the further spread of the patches in the remainder, or to prevent recurrences in some of the cases apparently cured, and the occasional dilatory manner with which some of the patches covered with a new growth of hair, induced me to try two of the newer remedies—the X-ray as recommended by Kienbock, Holzknecht, Schiff, Freund and others, and trikresol, as recommended by McGowan.

The X-ray, as used by Kienbock and others, is applied to the entire scalp during four sittings of about ten minutes' duration. This induces a general alopecia of about four weeks' duration, with the exception that a small border of hair persists around the patches, which is less marked around the newer areas and more marked around the older ones. The hair returns to the patches of alopecia more rapidly than the epilated hair in the normal areas.

Trikresol, as its name implies, is a combination of three cresols, para, meta and ortho, and though strongly antiseptic, is much less irritating and caustic than crude carbolic acid, features which render the use of the latter in alopecia areata impractical and dangerous. Trikresol was first employed by McGowan, of California, who has reported very favorable results, as observed from a series of eight cases.

In order to determine the relative merits of these two agents the X-ray and trikresol, not only as compared with each other, but also as compared with older remedies and untreated patches, the following control experiments were carefully carried out.

For the purpose, a favorable case with multiple patches, J. M., aged fifteen years, which had successfully resisted the most careful and painstaking treatment with chrysarobin, iodized collodion, bichloride, compresses with galvanism, pyrogallic acid and corrosive sublimate in ether and alcohol for almost a year, was selected. The alopecia first manifested itself in March, 1900, when patient returned from a barber-shop for a St. Patrick's-day hair-cut. The process steadily spread until it assumed the character as demonstrated by Figs. 1 and 2, which were taken on the occasion of the patient's first visit, February 28, 1901. Notwithstanding the most careful and routine treatment with the remedies above mentioned, covering a period of over eight months, the disease remained entirely uninfluenced by the treatment, and patient withdrew from further observation and treatment.

Patient presented himself on March 3, 1902, for the second time, the disease in the meantime having failed to show the least improvement, the denuded areas covering relatively the same extent of surface as shown in the original photographs, and had remained absolutely devoid of every vestige of hair. The denuded areas covered a large surface of the scalp, patches of relatively large size were present over the anterior and the two lateral aspects of the scalp, as shown in Figs. 1 and 2, and six smaller circumscribed areas were present over the posterior aspect and top of the head. The larger anterior and right lateral patch, as well as the smaller ones, with the exception of two posterior ones, were subjected to topical applications of trikresol, which was applied twenty-seven times, on an average of once a week, from the early part of March to the early part of September. The trikresol,

[1] Abstracted from the *Cincinnati Lancet Clinic*.

in the beginning, was applied pure, by means of cotton swab, the areas being previously cleaned from fat and oil with xylol, to insure greater and deeper penetration. The local irritation and pain attending its use was of short duration, and was allayed in a measure by the application of ice-cold compresses. Later this irritation was materially diminished by using a 50 per cent. solution of trikresol in alcohol. Its use was attended by erythema and a slight vesicular dermatitis, which disappeared with some scaliness, usually after a week's duration. The left lateral patch was subjected to the influence of the X-ray, the surrounding areas being carefully protected from its action by means of sheets of lead and tin foil. Five exposures were made at a focal distance of seven inches and a spark-gap three inches (Kinraide coil, Swett and Lewis tube), of ten minutes' duration, on March 8, 15, 20, 22 and April 1. These exposures were followed by a well-marked erythema, which manifested itself on April 4 and persisted for several weeks. The two posterior patches were left untreated. After an interval of about six weeks the areas which were subjected to the action of trikresol began to show a uniform growth of fine lanugo hair, the other remained unchanged. On May 5 the remaining patches were subjected to trikresol, with the result that by July 1 the patches originally treated with trikresol were well covered with a good growth of well-developed hair, and the two former untreated patches were covered with lanugo hair. The X-ray patch remained unchanged, being perfectly smooth and absolutely devoid of hair, with the exception of a narrow peripheral border of lanugo hair over an area that was in a measure shielded from X-ray action by lead and tin foil. On August 27, 1902, all the areas with the exception of the one which was subjected to X-ray action were well-covered with hair, as shown in Figs. 3 and 4, from photographs taken on that date. The X-ray patch on this date was still absolutely devoid of hair, although trikresol applications had been regularly made since the beginning of May.

It is an easy matter to infer from the foregoing case that trikresol is an efficient remedy for the treatment of alopecia areata, prompt and favorable in its results, and more efficacious than chrysarobin, iodized collodin, sublimate and the X-ray. The X-ray, on the other hand, was not only devoid of results, but influenced the patches so unfavorably that the recovery under trikresol medication has been unnecessarily prolonged. That the recovery was not in the nature of a mere coincidence, due to the self-limited course of the disease, is evidenced by the untreated patches, which made no change toward recovery until trikresol treatment was instituted. That the influence of the X-ray was positively unfavorable, and not merely incidental to the selection of a patch by nature unfortunate, is evidenced by the fact that trikresol subsequently failed to favorably influence it, except its borders, which were shielded from its action by lead and tin foil. This very marked unfavorable action of the X-ray discouraged its application in subsequent cases.

The favorable results with trikresol in this case prompted its use in a number of other cases, with equally gratifying results. (Seven cases given.)

SOME OBSTINATE BLADDER CASES.

By Dr. George W. Hopkins,
Cleveland, Ohio.

John C—, aet. 31; occupation, patrolman. Following exposure, patient experienced bladder symptoms as follows: Frequent urination, tenesmus, hypogastric pain and a temperature of 101.4 degrees. The urine was scanty, turbid and loaded with mucus. Diagnosis, Acute cystitis.

Treatment consisted of rest in bed, restricted diet, anodynes for the tenesmus, diluent and alkaline drinks.

The acute symptoms promptly subsided, but the urine continued abnormal despite the general measures employed and the internal administration of urinary antiseptics.

Irrigation with boric acid solutions of varying strength proved unsatisfactory, as did also solutions of potassium permanganate and silver nitrate similarly applied. A 20-per-cent. solution of glyco-thymoline was then substituted for irrigation, and the improvement was marked and continuous until recovery was perfect.

Harry R—, aet. 43; occupation, bookkeeper. Had a history of bladder trouble of several years' duration. His urine was blood-tinged and loaded with mucus.

Microscopic examination revealed an abundance of ammonia, magnesium phosphates, numerous disintegrating pus corpuscles, blood corpuscles and blood shadows. Repeated examinations with the sound gave negative results, but a skiograph taken with a high vacuum

hard tube revealed a small calculus which had persistently evaded the sound in previous examination. Lithotomy was performed and the calculus removed, but the urine failed to return to normal.

Irrigation in turn with boric acid potassium permanganate and silver nitrate solutions proved satisfactory from the start and recovery was ultimately perfect.

William L., aet. 55; occupation, saloon keeper. Had a history of repeated attacks of gonorrhea which were never properly treated.

Urine was voided with great difficulty, at frequent intervals, and loaded with mucus. Reaction was alkaline and the microscope revealed an abundance of amorphous phosphates of calcium and magnesium, flat epithelial cells, disintegrating pus corpuscles and indigo crystals.

Catelectrolysis by the slow method removed the stricture and Bottini's operation relieved the enlarged prostate, but the urine failed to clear up as desired.

The cystoscope showed marked changes in the bladder walls but catheterization of the ureters yielded negative results. Appropriate urinary antiseptics were administered internally and creolin and silver nitrate solutions by vesical irrigation with only slight improvement. Irrigations with 20-per-cent. solutions of glyco-thymoline gave early and continuous improvement until recovery was perfect.

CASE CYSTITIS SUCCESSFULLY TREATED WITH GLYCO-THYMOLINE.

By O. G. Fegley, M. D.,
Philadelphia, Pa.

This case was the severest I have met with in my experience, and for a time I despaired of a cure.

Mrs. H., 48, primipara, was delivered by me after having been in labor for three days. She developed a severe cystitis on the fourth day; the ordinary remedies were given, but without avail.

The symptoms increased in severity, tenesmus, intense pain, blood epithelium and pus. Soda salicylate, boric acid, protargol, etc., were used topically, while the usual remedies were administered internally.

In fact, I tried every remedy known to me, but the conditions remained most grave.

At this time glyco-thymoline was forced on my attention and I felt I could do no less than to try it, for I had been doing my utmost for two weeks past and my patient suffering intensely during that time.

Accordingly I washed out the bladder with hot 25-per-cent. solution glyco-thymoline, which gave instant relief from the pain; this I did twice a day for two weeks. The improvement was rapid, the distressing symptoms disappeared and the patient was completely cured.

I have since used it with beneficial results in several other cases of cystitis.

PURE STRONTIUM SALTS.

By F. S. Mason, M.P.S. (G.B.)

The precise investigations of Dr. Laborde, communicated to the French Academy of Medicine and the Society of Biology, prove that pure Strontium salts (Paraf-Javal), far from being harmful, have on the contrary a favorable influence on the phenomena of nutrition.

Laborde found that much of the good which was produced when the strontium preparations were administered was due to the antiseptic influence exerted on the kidneys and bowels during their elimination. His experiments demonstrated that dogs and other animals grew fat, and that their general health improved where Paraf-Javal's pure Strontium salts (which are free from toxic Barium) were regularly mixed with their food. Where potassium or sodium salts were fed to the same animals, this effect was entirely wanting; on the other hand, it was soon apparent under such circumstances that the hair became rough, loss in weight was promptly noted and sooner or later death resulted.

This bears out the statement of Shoemaker that "Potassium is a cardiac poison, a muscle and nerve paralyzer (through its influence upon protoplasm), and destructive to the ozonizing function of the red blood corpuscles."

Dr. Leon L. Soloman in the *American Therapist* of November, 1898, cleverly sums up the advantages of the Strontium salts, over the salts of other bases as follows:

(*a*) "The element, strontium, seems to be not only non-irritating, but actually possessed of sedative property, which is manifested to a greater or lesser degree throughout all of the preparations of strontium.

(*b*) "It forms chemical union with radicals, to produce preparations identical with those of potassium and sodium.

(*c*) "On account chiefly of their sedative properties, the various salts of strontium may be profitably employed to take the place of the corresponding salts of either potassium or sodium."

Professors Germain See and Fere have shown the absolute innocuousness and remarkable action of Strontium salts, the purity of which they considered to be an absolute sine qua non for therapeutic efficiency, and, for their own tests, made exclusive use of the Strontium salts made by the Paraf-Javal process.

Clinical proof of the advantages of the Strontium Lactate, Bromide, Iodide and Salicylate (over similar Ammonium, Potassium and Sodium salts) is abundant.

Drs. Constantin Paul and Dujardin-Beaumetz found that Bromide of Strontium (Paraf-Javal) possessed the indisputable advantage of being better borne by the stomach than the other alkaline bromides.

Professor Germain See says: "It never produces any disastrous effect on the stomach even in large doses. Of thirty-two patients suffering from gastric dilatation, all improved and some were altogether cured. It prevents the acetic and lactic fermentations and the formation of the gases of decomposition, relieves nervo-gastric irritation and controls morbid gastro-intestinal fermentation without causing depression." (Academie de Médicine, October, 1891.)

The indications are those of bromide of potassium, in such nervous affections as epilepsy, hysteria, asthma, chorea, paralysis with involuntary agitation, and dyspepsia in its various forms.

Strontium Iodide (Paraf-Javal), by increasing intravascular pressure, relieves the nervous irritation of the heart and thus strengthens its contractions

without adding to their number, while as compared with the Potassium salt, it is less violent and abrupt in its effects.

The Iodide is indicated in vascular affections relating to lesions of the myocardium and intracardiac orifices, asthma, angina pectoris, scrofulous manifestations, eczema and syphilis.

Lactate of Strontium (Paraf-Javal) exercises a favorable influence on the gastro-intestinal functions, hence it is indicated in conditions of depraved nutrition, diabetes and albuminuria.

Dr. Constantin Paul employed it with advantage in visceral congestion (in which it gave better results than lithia) and in Bright's Disease, and his observations have been confirmed by others, showing that Lactate of Strontium (Paraf-Javal) is indicated in parenchymatous, rheumatismal and epithelial nephritis; in the nephritis of gouty and scrofulous patients, and in the albuminuria of pregnant or recently delivered women. Dr. Bucquoy found that the amount of albumin in the urine was reduced one-half within twenty-four hours after the beginning of treatment.

The essential point in preferring Strontium Bromide, Iodide, Lactate, etc., being their absolute purity, those prepared by the Paraf-Javal process only should be used.

These are exempt from even traces of toxic Barium salts, and if tested with a saturated solution of strantium chromate, their solutions do not give even the slightest cloudiness, whereas the impurity of the commercial salts is betrayed by this reagent. Strontium Bromide, Iodide, Lactate and Salicylate are prescribed in the same doses as the potassium, sodium or ammonium salts, but act more promptly and in many cases even smaller doses give good results.

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Standard Solution of Lactate (Paraf-Javal) 60 grains to oz.
Standard Solution of Iodide (Paraf-Javal) 30 grains to oz.

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